



SERVICE CENTER
901 Peninsula Corporate Circle
Boca Raton, FL 33487
(800) 622-4123

June 27, 2017

PRIME PAINTERS LLC
1760 SHADY CREEK LN
LAWRENCEVILLE, GA 30043-2709

EFFECTIVE DATE: 06/15/2017
BINDER NUMBER: 10-10804-17178-355702
FED ID NUMBER: [REDACTED] 4723
APPLICATION ID: 42231500

RE: WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY BINDER

This is to acknowledge receipt of an initial or deposit premium payment and your application for coverage through the Workers Compensation Insurance Plan for the State of GEORGIA.

Coverage is provided under this binder, beginning at 12:01 A.M. on the effective date shown above, and with the insurance company named below, and shall remain in effect until canceled or a policy has been issued. In accordance with Plan Procedures, coverage is provided under the Workers Compensation Law of GEORGIA and of such additional jurisdictions as may be requested, in accordance with the Plan rules. Employers liability coverage is also provided, subject to the standard limits prescribed in the Basic Manual, unless higher limits have been requested in accordance with the Plan rules.

Please retain this binder as evidence of the coverage until you receive your policy.

INSURANCE COMPANY:

TRAVELERS PROPERTY CASUALTY CO OF AMERICA
BALDWIN POINT
2420 LAKEMONT AVENUE
ORLANDO, FL 32814

AGENCY NAME:

FOSTER AND ASSOCIATES DBA FOSTER WITMER INS AGENCY
3100 BRECKINRIDGE BLVD STE 510
DULUTH, GA 30096-7507

NOTICE

COVERAGE FOR THIS EMPLOYER HAS BEEN PLACED THROUGH THE ASSIGNED RISK PLAN. AS THE PLAN IS THE MARKET OF LAST RESORT, COVERAGE SHOULD CONTINUE TO BE SOUGHT THROUGH THE STANDARD/VOLUNTARY MARKET. PLEASE NOTE THAT PREMIUMS IN THE ASSIGNED RISK PLAN MAY BE HIGHER THAN THE STANDARD/VOLUNTARY MARKET.

If a policy issued by an insurance carrier, pursuant to an assignment under the Workers Compensation Insurance Plan, is canceled due to the employer's failure to comply with terms or conditions of the policy, such employer may be ineligible for further coverage under the Plan.

NOTICE

**POLICYHOLDER DISCLOSURE
NOTICE OF TERRORISM
INSURANCE COVERAGE
FOR THE STATE(S) OF GEORGIA**

Your policy provides coverage for losses resulting from acts of terrorism. Coverage for such losses is still subject to all terms, definitions, exclusions, and conditions in your policy, and any applicable federal and/or state laws, rules, or regulations. You are notified that under the Terrorism Risk Insurance Act of 2002(Act) and any amendments, including as amended and extended through December 31, 2020 by the Terrorism Risk Insurance Program Reauthorization Act of 2015, the term "act of terrorism" means any act or acts that are certified by the Secretary of the Treasury — in consultation with the Secretary of Homeland Security, and the Attorney General of the United States — to be an act of terrorism; to be a violent act or an act that is dangerous to human life, property, or infrastructure; to have resulted in damage within the United States, or outside the United States in the case of certain air carriers or vessels or the premises of a United States mission; and to have been committed by an individual or individuals as part of an effort to coerce the civilian population of the United States or to influence the policy or affect the conduct of the United States Government by coercion.

Under your coverage, any losses resulting from certified acts of terrorism may be partially reimbursed by the United States Government under a formula established by the Act, as amended. Under the formula, the United States Government generally reimburses 85% through 2015; 84% beginning on January 1, 2016; 83% beginning on January 1, 2017; 82% beginning on January 1, 2018; 81% beginning on January 1, 2019 and 80% beginning on January 1, 2020, of covered terrorism losses exceeding the statutorily established deductible paid by the insurance company providing the coverage.

The Terrorism Risk Insurance Act, as amended, also contains a \$100 billion cap that limits U.S. Government reimbursement as well as insurers' liability for losses resulting from certified acts of terrorism. If the aggregate insured losses for all insurers exceed \$100 billion in any one calendar year, and the insurance company providing the coverage has met its statutorily established deductible, the insurance company is not liable for payment of any portion of the amount of insured losses that exceed \$100 billion. Further, the United States Government will not make any payment under the Act for any portion of insured losses that exceed \$100 billion. For aggregate insured losses up to \$100 billion, the insurance company will pay only a pro rata share of such losses as determined by the Secretary of Treasury.

The portion of your total estimated annual premium that currently is attributable to coverage for insured losses resulting from certified acts of terrorism is \$.00 and does not include any charges for the portion of losses covered by the United States Government under the Act.

NOTICE

CERTIFICATES OF INSURANCE

Effective upon receipt of the enclosed binder, the producer may issue certificates of insurance only under the following conditions: 1) that the certificate is issued only on the standard ACORD form; 2) that the

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certificate is issued only for operations in the states listed in 3.A. of the Information Page; 3) that the policy terms are unchanged; 4) that the certificate holder is not extended any greater rights than those extended to the insured; and 5) that the assigned carrier is provided with a copy of each certificate.

APPLICATION NOTES:

Producer/Employers: Please be advised that Assigned Risk Carriers are required to conduct interim audits, loss prevention surveys and final audits on Assigned Risk policies. Therefore, Failure to comply with an Assigned Risk Carrier request may result in cancellation of this policy in accordance with the applicable state laws.

As a result of the passage of Georgia House Bill 1679, Chapter 120-2-38 of the Rules and Regulations of the Office of the Commissioner of Insurance has established three categories of risks within the Georgia Workers Compensation Insurance Plan. The categories are as follows:

"Group 1" means risks which have insufficient prior workers' compensation experience to be experience rated.

"Group 2" means risks which are not Group 1 or Group 3 risks.

"Group 3" means risks which have an experience rating modification greater than 1.0.

Group 1 risks will be subject to a Merit Rating Program. The assigned risk manual rates shall apply to those risks assigned to Group 2. The premium of Group 3 risks may be adjusted based on their loss experience, upon the approval of such rating program. This may affect your workers compensation premium in the Georgia Workers Compensation Insurance Plan.

Coverage is being bound subject to your signed statement on the application acknowledging and agreeing to the terms of the Loss Sensitive Rating Plan (LSRP). In the event that you meet the eligibility requirements of the LSRP, a LSRP contingent deposit premium equal to 20% of standard premium will be required.

Application was processed by producer using the NCCI RMAPS(R) Online Application Service.

CARRIER: Coverage has been requested for the following states: GA.

Officers/LLC Members have elected to be excluded from coverage.

The Georgia non-cooperation with premium audit endorsement is used to notify an employer that a payroll amount of three times the estimated payroll may be used as a result of failing to cooperate with a workers compensation premium audit.

PRODUCER/EMPLOYER: Please forward a signed officer exclusion letter or form to the carrier (as named on the binder) within the time specified by statutory requirement or you may be subject to additional premium for any officers listed on the application. If mandated by the state, the signed officer exclusion form must be sent to the state. If an exclusion form or letter is already attached with your application, please send a copy to the state only.

Increased Limits of Liability have been requested.

Please forward form 941 (or its equivalent) to the carrier as named on the binder or forward a written statement explaining why tax documentation cannot be provided.

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CARRIER: Please send the Agent of Record a copy of all items/documentations sent to the insured.

Prior history found, insufficient premium size, this risk is not currently experience rated.

PRODUCER/EMPLOYER: Please provide a description of the owner's duties to carrier.

GA: CARRIER: This minimum premium application does not qualify for merit rating. The work sheet is being provided for use in the event this policy should exceed the minimum premium threshold during the policy period.

The premium reflected on the Premium Calculation Worksheet is the Total Estimated Annual Premium. The Assigned Carrier may apply additional state surcharges, taxes, assessments, or programs as required by the state.



APP# 42231500

FACSIMILE TRANSMISSION

From: PRIME PAINTERS LLC

Fax #: (770) 717-7482

Correspondence can be uploaded directly to the application via the Communication tab. If you choose to fax the requested information to NCCI this cover sheet must accompany all correspondence in regard to Application ID # 42231500

Please note: Failing to use the provided cover sheet along with any faxed correspondence may delay application processing. In order to expedite application processing please be sure to attach the cover sheet to all faxed documents.

Should you have any problem with this transmission, please call:

(800) 622-4123 Ext. 1136

APP# 42231500

Return Fax: (561) 893-4230

**WORKERS COMPENSATION APPLICATION**

DATE (MM/DD/YYYY)

06/14/2017

AGENCY NAME AND ADDRESS FOSTER AND ASSOCIATES DBA FOSTER WITMER INS AGENCY 3100 BRECKINRIDGE BLVD STE 510 DULUTH,GA 30096-7507		COMPANY:	
PRODUCER NAME: VICKI NEVILLE		UNDERWRITER:	
CS REPRESENTATIVE NAME: VICKI NEVILLE		APPLICANT NAME: PRIME PAINTERS LLC	
OFFICE PHONE (A/C. No. Ext): (770) 717-7380		OFFICE PHONE: (770) 827-1115	MOBILE PHONE:
MOBILE PHONE:		MAILING ADDRESS (Including Zip + 4) 1760 SHADY CREEK LN LAWRENCEVILLE,GA 30043-2709	
FAX (A/C.NO): (770) 717-7482		YRS IN BUS: 10	
EMAIL ADDRESS: VICKI@FOSTERWITMER.COM		SIC:	
CODE:		NAICS:	
SUB CODE:		Website Address:	
AGENCY CUSTOMER ID:		E-MAIL ADDRESS	
		SOLE PROPRIETOR <input type="checkbox"/> CORPORATION <input checked="" type="checkbox"/> LLC <input type="checkbox"/> TRUST <input type="checkbox"/> UNINCORPORATED ASSOCIATION <input type="checkbox"/>	
		PARTNERSHIP <input type="checkbox"/> SUBCHAPTER "S" CORP <input type="checkbox"/> JOINT VENTURE <input type="checkbox"/> OTHER <input type="checkbox"/>	
		CREDIT BUREAU NAME:	
		ID NUMBER:	
		FEDERAL EMPLOYER ID NUMBER	NCCI RISK ID NUMBER:
		4723	
		OTHER RATING BUREAU ID EMPLOYER REGISTRATION NUMBER OR STATE	

STATUS OF SUBMISSION**BILLING / AUDIT INFORMATION**

<input type="checkbox"/> QUOTE	<input type="checkbox"/> ISSUE POLICY	BILLING PLAN	PAYMENT PLAN	AUDIT
<input type="checkbox"/> BOUND (Give date and/or attach copy)		<input type="checkbox"/> AGENCY BILL	<input type="checkbox"/> ANNUAL <input type="checkbox"/> OTHER:	<input type="checkbox"/> AT EXPIRATION <input type="checkbox"/> MONTHLY
<input checked="" type="checkbox"/> ASSIGNED RISK (Attach ACORD 133)		<input type="checkbox"/> DIRECT BILL	<input type="checkbox"/> SEMI-ANNUAL	<input type="checkbox"/> SEMI-ANNUAL
			<input type="checkbox"/> QUARTERLY % DOWN:	<input type="checkbox"/> QUARTERLY

LOCATIONS

LOC #	Highest Floor	STREET, CITY, COUNTY, STATE, ZIP CODE
1		1760 SHADY CREEK LN LAWRENCEVILLE,GA 30043-2709

POLICY INFORMATION

PROPOSED EFF DATE 6/15/2017		PROPOSED EXP DATE 6/15/2018		NORMAL ANNIVERSARY RATING DATE		<input type="checkbox"/> PARTICIPATING		RETRO PLAN	
						<input type="checkbox"/> NON-PARTICIPATING			
PART 1 - WORKERS COMPENSATION (States)		PART 2 - EMPLOYER'S LIABILITY		PART 3 - OTHER STATES INS		DEDUCTIBLES (N / A in WI)		AMOUNT / % (N / A in WI)	
GA		\$ 1,000,000 EACH ACCIDENT				<input type="checkbox"/> MEDICAL		<input type="checkbox"/> U.S.L. & H.	
		\$ 1,000,000 DISEASE-POLICY LIMIT				<input type="checkbox"/> INDEMNITY		<input type="checkbox"/> VOLUNTARY COMP	
		\$ 1,000,000 DISEASE-EACH EMPLOYEE						<input type="checkbox"/> FOREIGN COV	
DIVIDEND PLAN/SAFETY GROUP		ADDITIONAL COMPANY INFORMATION							
SPECIFY ADDITIONAL COVERAGES / ENDORSEMENTS (Attach ACORD 101, Additional Remarks Schedule, if more space is required)									

TOTAL ESTIMATED ANNUAL PREMIUM - ALL STATES

TOTAL ESTIMATED ANNUAL PREMIUM ALL STATES \$1,620.00	TOTAL MINIMUM PREMIUM ALL STATES \$0.00	TOTAL DEPOSIT PREMIUM ALL STATES \$1,620.00
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CONTACT INFORMATION

TYPE	NAME	OFFICE PHONE	MOBILE PHONE	E-MAIL
INSPECTION	EMIL SUIUGAN	(770) 827-1115		
ACCTING RECORD	EMIL SUIUGAN	(770) 827-1115		
CLAIMS INFO	EMIL SUIUGAN	(770) 827-1115		

INDIVIDUALS INCLUDED / EXCLUDED

PARTNERS, OFFICERS, RELATIVES (Must be employed by business operations) TO BE INCLUDED OR EXCLUDED (Remuneration/Payroll to be included must be part of rating information section.) Exclusions in Missouri must meet the requirements of Section 287.090 RSMo.									
STATE	LOC #	NAME	DATE OF BIRTH	TITLE/ RELATIONSHIP	OWNER-SHIP %	DUTIES	INC/EXC	CLASS CODE	REMUNERATION/ PAYROLL
GA		SUIUGAN, EMIL		MEMBER	100	OWNER/OPERATOR	E	5474	56300

RATING INFORMATION - STATE: Georgia[illegible]

PREMIUM

STATE:	FACTOR	FACTORED PREMIUM		FACTOR	FACTORED PREMIUM
TOTAL	N / A	\$0			\$0
INCREASED LIMITS		\$120.00	SCHEDULE RATING *		\$0
DEDUCTIBLE *	0	\$0	CCPAP		
			STANDARD PREMIUM		\$105.00
EXPERIENCE OR MERIT MODIFICATION	0	\$0	PREMIUM DISCOUNT		\$0.00
		\$0	EXPENSE CONSTANT	N / A	\$160.00
ASSIGNED RISK SURCHARGE *	0	\$0.00	TAXES / ASSESSMENTS *	N / A	\$0.00
ARAP *	0.00	\$0.00			\$0

* N / A in Wisconsin

TOTAL ESTIMATED ANNUAL PREMIUM	MINIMUM PREMIUM	DEPOSIT PREMIUM
\$1,620.00	\$1,620.00	

REMARKS (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)

NCCI APP# 42231500

PRIOR CARRIER INFORMATION / LOSS HISTORY

PROVIDE INFORMATION FOR THE PAST 5 YEARS AND USE THE REMARKS SECTION FOR LOSS DETAILS						LOSS RUN ATTACHED
YEAR	CARRIER & POLICY NUMBER	ANNUAL PREMIUM	MOD	# CLAIMS	AMOUNT PAID	RESERVE
	CO:					
	POL #:					
	CO:					
	POL #:					
	CO:					
	POL #:					
	CO:					
	POL #:					
	CO:					
	POL #:					
	CO:					
	POL #:					

NATURE OF BUSINESS / DESCRIPTION OF OPERATIONS

GIVE COMMENTS AND DESCRIPTIONS OF BUSINESS, OPERATIONS AND PRODUCTS: MANUFACTURING - RAW MATERIALS, PROCESSES, PRODUCT, EQUIPMENT; CONTRACTOR - TYPE OF WORK, SUB-CONTRACTS; MERCANTILE - MERCHANDISE, CUSTOMERS, DELIVERIES; SERVICE - TYPE, LOCATION; FARM - ACREAGE, ANIMALS, MACHINERY, SUB-CONTRACTS.

PAINTING

GENERAL INFORMATION

EXPLAIN ALL "YES" RESPONSES	Y / N
1. DOES APPLICANT OWN, OPERATE OR LEASE AIRCRAFT / WATERCRAFT?	N
2. DO / HAVE PAST, PRESENT OR DISCONTINUED OPERATIONS INVOLVE(D) STORING, TREATING, DISCHARGING, APPLYING, DISPOSING, OR TRANSPORTING OF HAZARDOUS MATERIAL? (e.g. landfills, wastes, fuel tanks, etc)	N
3. ANY WORK PERFORMED UNDERGROUND OR ABOVE 15 FEET?	N
4. ANY WORK PERFORMED ON BARGES, VESSELS, DOCKS, BRIDGE OVER WATER?	N
5. IS APPLICANT ENGAGED IN ANY OTHER TYPE OF BUSINESS?	N
6. ARE SUB-CONTRACTORS USED? (If "YES", give % of work subcontracted)	N
7. ANY WORK SUBLET WITHOUT CERTIFICATES OF INSURANCE? (If "YES", payroll for this work must be included in the State Rating Worksheet on Page 2)	N
8. IS A WRITTEN SAFETY PROGRAM IN OPERATION?	N
9. ANY GROUP TRANSPORTATION PROVIDED?	N
10. ANY EMPLOYEES UNDER 16 OR OVER 60 YEARS OF AGE?	N
11. ANY SEASONAL EMPLOYEES?	N
12. IS THERE ANY VOLUNTEER OR DONATED LABOR? (If "YES", please specify)	N
13. ANY EMPLOYEES WITH PHYSICAL HANDICAPS?	N
14. DO EMPLOYEES TRAVEL OUT OF STATE? (If "YES", indicate state(s) of travel and frequency)	N
15. ARE ATHLETIC TEAMS SPONSORED?	N
16. ARE PHYSICALS REQUIRED AFTER OFFERS OF EMPLOYMENT ARE MADE?	N

EXPLAIN ALL "YES" RESPONSES	Y / N
17. ANY OTHER INSURANCE WITH THIS INSURER?	N
18. ANY PRIOR COVERAGE DECLINED / CANCELLED / NON-RENEWED IN THE LAST THREE (3) YEARS? (Missouri Applicants – Do not answer this question) CURRENT CARRIER NON RENEWED NO LONGER WRITING IN GEORGIA	Y
19. ARE EMPLOYEE HEALTH PLANS PROVIDED?	N
20. DO ANY EMPLOYEES PERFORM WORK FOR OTHER BUSINESSES OR SUBSIDIARIES?	N
21. DO YOU LEASE EMPLOYEES TO OR FROM OTHER EMPLOYERS?	N
22. DO ANY EMPLOYEES PREDOMINANTLY WORK AT HOME? If "YES", # of Employees: _____	N
23. ANY TAX LIENS OR BANKRUPTCY WITHIN THE LAST FIVE (5) YEARS? (If "YES", please specify)	N
24. ANY UNDISPUTED AND UNPAID WORKERS COMPENSATION PREMIUM DUE FROM YOU OR ANY COMMONLY MANAGED OR OWNED ENTERPRISES? (If "YES", explain including entity name(s) and policy number(s))	N

SIGNATURE

Copy of the Notice of Information Practices (Privacy) has been given to the applicant. (Not required in all states, contact your agent or broker for your state's requirements.)			
<p>PERSONAL INFORMATION ABOUT YOU, INCLUDING INFORMATION FROM A CREDIT OR OTHER INVESTIGATIVE REPORT, MAY BE COLLECTED FROM PERSONS OTHER THAN YOU IN CONNECTION WITH THIS APPLICATION FOR INSURANCE AND SUBSEQUENT AMENDMENTS AND RENEWALS. SUCH INFORMATION AS WELL AS OTHER PERSONAL AND PRIVILEGED INFORMATION COLLECTED BY US OR OUR AGENTS MAY IN CERTAIN CIRCUMSTANCES BE DISCLOSED TO THIRD PARTIES WITHOUT YOUR AUTHORIZATION. CREDIT SCORING INFORMATION MAY BE USED TO HELP DETERMINE EITHER YOUR ELIGIBILITY FOR INSURANCE OR THE PREMIUM YOU WILL BE CHARGED. WE MAY USE A THIRD PARTY IN CONNECTION WITH THE DEVELOPMENT OF YOUR SCORE. YOU MAY HAVE THE RIGHT TO REVIEW YOUR PERSONAL INFORMATION IN OUR FILES AND REQUEST CORRECTION OF ANY INACCURACIES. YOU MAY ALSO HAVE THE RIGHT TO REQUEST IN WRITING THAT WE CONSIDER EXTRAORDINARY LIFE CIRCUMSTANCES IN CONNECTION WITH THE DEVELOPMENT OF YOUR CREDIT SCORE. THESE RIGHTS MAY BE LIMITED IN SOME STATES. PLEASE CONTACT YOUR AGENT OR BROKER TO LEARN HOW THESE RIGHTS MAY APPLY IN YOUR STATE OR FOR INSTRUCTIONS ON HOW TO SUBMIT A REQUEST TO US FOR A MORE DETAILED DESCRIPTION OF YOUR RIGHTS AND OUR PRACTICES REGARDING PERSONAL INFORMATION. (Not applicable in AZ, CA, DE, KS, MA, MN, ND, NY, OR, VA, or WV. Specific ACORD 38s are available for applicants in these states.) (Applicant's Initials): _____</p>			
<p>Applicable in AL, AR, DC, LA, MD, NM, RI and WV: Any person who knowingly (or willfully)* presents a false or fraudulent claim for payment of a loss or benefit or knowingly (or willfully)* presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. *Applies in MD Only.</p>			
<p>Applicable in CO: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.</p>			
<p>Applicable in FL and OK: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony (of the third degree)*. *Applies in FL Only.</p>			
<p>Applicable in KS: Any person who, knowingly and with intent to defraud, presents, causes to be presented or prepares with knowledge or belief that it will be presented to or by an insurer, purported insurer, broker or any agent thereof, any written statement as part of, or in support of, an application for the issuance of, or the rating of an insurance policy for personal or commercial insurance, or a claim for payment or other benefit pursuant to an insurance policy for commercial or personal insurance which such person knows to contain materially false information concerning any fact material thereto; or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act.</p>			
<p>Applicable in KY, NY, OH and PA: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties (not to exceed five thousand dollars and the stated value of the claim for each such violation)*. *Applies in NY Only.</p>			
<p>Applicable in ME, TN, VA and WA: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties (may)* include imprisonment, fines and denial of insurance benefits. *Applies in ME Only.</p>			
<p>Applicable in NJ: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.</p>			
<p>Applicable in OR: Any person who knowingly and with intent to defraud or solicit another to defraud the insurer by submitting an application containing a false statement as to any material fact may be violating state law.</p>			
<p>Applicable in PR: Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation by a fine of not less than five thousand dollars (\$5,000) and not more than ten thousand dollars (\$10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances [be] present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.</p>			
<p>Applicable in UT: Any person who knowingly presents false or fraudulent underwriting information, files or causes to be filed a false or fraudulent claim for disability compensation or medical benefits, or submits a false or fraudulent report or billing for health care fees or other professional services is guilty of a crime and may be subject to fines and confinement in state prison.</p>			
THE UNDERSIGNED IS AN AUTHORIZED REPRESENTATIVE OF THE APPLICANT AND REPRESENTS THAT REASONABLE INQUIRY HAS BEEN MADE TO OBTAIN THE ANSWERS TO QUESTIONS ON THIS APPLICATION. HE/SHE REPRESENTS THAT THE ANSWERS ARE TRUE, CORRECT AND COMPLETE TO THE BEST OF HIS/HER KNOWLEDGE.			
APPLICANT'S SIGNATURE (Must be Officer, Owner or Partner)	DATE	PRODUCER'S SIGNATURE	NATIONAL PRODUCER NUMBER

**WORKERS COMPENSATION INSURANCE PLAN
ASSIGNED RISK SECTION**DATE (MM/DD/YYYY)
06/14/2017

THIS FORM ALONG WITH AN ACORD 130 WORKERS COMPENSATION APPLICATION CONSTITUTE AN APPLICATION FOR WORKERS COMPENSATION INSURANCE PLAN (ASSIGNED RISK) COVERAGE. THIS FORM MUST BE ATTACHED TO AN ACORD 130 FOR SUBMISSION. PLEASE REFER TO THE STATE SPECIFIC INSTRUCTIONS PAGE FOR SPECIFIC REQUIREMENTS.

APPLICANT NAME
PRIME PAINTERS LLCPROPOSED EFF DATE
06/15/2017**SUPPLEMENTAL INFORMATION**

PAYROLL OFFICE NAME, ADDRESS AND TELEPHONE NUMBER (A PO BOX ADDRESS ALONE IS NOT ACCEPTABLE. PLEASE PROVIDE DRIVING INSTRUCTIONS IF A ROUTE ADDRESS IS SHOWN.)

EMIL SUIUGAN
1760 SHADY CREEK LN
LAWRENCEVILLE,GA 30043-2709

STATE DEVELOPING HIGHEST PAYROLL: GA

EXPLAIN ALL "YES" RESPONSES IN THE REMARKS SECTION

1. HAS THERE BEEN PREVIOUS WORKERS COMPENSATION COVERAGE:

IN THIS STATE?

IN ANY OTHER STATE?

-IF NO TO BOTH QUESTIONS. WAS THIS DUE TO: ☐ NEW BUSINESS ☐ SELF INSURED-INDEP ☐ SELF INSURED-GROUP ☐ # EMPLOYEES

Y

☐☐

N

2. IS THERE ANY UNPAID WORKERS COMPENSATION PREMIUM DUE OR IN DISPUTE FROM YOU OR ANY COMMONLY MANAGED OR OWNED ENTERPRISES? IF YES. EXPLAIN INCLUDING ENTITY NAME(S) AND POLICY NUMBER(S).

☐

N

3. YEAR APPLICANT'S BUSINESS BEGAN: 2007

4. HAS THERE BEEN A NAME CHANGE, CONSOLIDATION, MERGER ACQUISITION, SALE, PURCHASE OR TRANSFER OF ASSETS OR OWNERSHIP CHANGE DURING THE PAST FIVE (5) YEARS? IF YES, PROVIDE A COMPLETED ERM-14 FORM.

☐

N

5. IS APPLICANT RELATED THROUGH COMMON MANAGEMENT OR OWNERSHIP TO ANY ENTITY NOT LISTED ON THE ACORD 130 FORM, WHETHER COVERAGE IS REQUIRED OR NOT? IF YES, PROVIDE A COMPLETED ERM-14 FORM.

☐

N

6. DO YOU LEASE WORKERS FROM A PROFESSIONAL EMPLOYER ORGANIZATION (PEO)? IF YES, REFER TO WCIP INSTRUCTIONS.

NAME OF PROFESSIONAL EMPLOYER ORGANIZATION (PEO):

☐

N

7. DO YOU LEASE WORKERS TO A CLIENT COMPANY? IF YES, REFER TO WCIP INSTRUCTIONS.

☐

N

8. ARE YOU SEEKING TO COVER THE LEASED WORKERS? IF YES, REFER TO WCIP INSTRUCTIONS.

☐

N

9. DO YOU PROVIDE TEMPORARY ARRANGEMENT SERVICES TO OTHER EMPLOYERS?
IF YES. PROVIDE A TEMPORARY LABOR CONTRACTOR EMPLOYEE FORM.☐

N

10. DO YOU HAVE A FRANCHISE OR LICENSING AGREEMENT? IF YES, PROVIDE A COPY OF THE AGREEMENT.

☐

N

11. IS COVERAGE REQUESTED FOR A SPORTS TEAM? IF YES, PROVIDE NAME OF SPORTS TEAM AND DOMICILED STATE.

NAME OF SPORTS TEAM:

DOMICILED STATE:

☐

N

12. DO TRUCKING CLASSIFICATIONS APPLY? IF YES, COMPLETE QUESTIONS 13 - 20.

☐

N

13. DO YOU OR YOUR EMPLOYEES REGULARLY OPERATE FROM A BASE TERMINAL(S) WHICH IS (ARE) USED TO LOAD, UNLOAD, STORE OR TRANSFER FREIGHT? IF YES, PLEASE PROVIDE A LIST OF TERMINAL ADDRESSES:

☐☐

#	STREET	CITY	COUNTY	ST	ZIP CODE
1					
2					
3					

14. CAN EACH DRIVER'S STATE OF MAJORITY DRIVING TIME BE ESTABLISHED THROUGH VERIFIABLE RECORDS OR LOGS?

☐☐

15. PLEASE PROVIDE A LIST OF ALL DRIVERS/HELPERS AND THEIR STATE OF RESIDENCE:

	DRIVER NAME	TERMINAL # (SEE ABOVE)	MAJORITY DRIVING STATE	RESIDENCE STATE
1				
2				
3				

16. WHAT TYPE(S) OF GOODS ARE BEING HAULED? (e.g., coal, dry goods, explosives, scaffolding, water / waste fluids from oil field sites, etc.)

17. DO YOU OWN THESE GOODS?

☐☐

18. IS APPLICANT UNDER EXCLUSIVE CONTRACT WITH ANY RETAIL STORE(S)? IF YES, PROVIDE COPY OF CONTRACT(S).

☐☐

19. IS APPLICANT UNDER EXCLUSIVE CONTRACT WITH ANY POSTAL SERVICE? IF YES, PROVIDE COPY OF CONTRACT(S).

☐☐

20. WITHIN WHAT MILE RADIUS IS HAULING DONE? # MILES:

INSURANCE COMPANIES WHO HAVE OFFERED/REFUSED INSURANCE					YES	NO
21. HAVE YOU RECEIVED ANY OFFERS OF VOLUNTARY COVERAGE? (INCLUDE MULTI-LINE OR RETROSPECTIVE RATING PLAN, IF APPLICABLE) IF YES, PROVIDE FULL DETAILS INCLUDING PLAN TERMS IN THE REMARKS SECTION.					<input type="checkbox"/>	<input checked="" type="checkbox"/> N
22. INDICATE THE NUMBER OF INSURANCE COMPANIES WHICH HAVE REFUSED THE APPLICANT COVERAGE IN THE LAST 60 DAYS (OR IN ACCORDANCE WITH STATE SPECIFIC GUIDELINES): 4						
LIST COMPANY NAMES, REPRESENTATIVE NAMES, TELEPHONE NUMBERS AND DATES OF REFUSALS. REFER TO WCIP TO VERIFY REQUIREMENTS.						
COMPANY NAME	REPRESENTATIVE NAME	TELEPHONE NUMBER	DATE OF REFUSAL	COMMENTS		
PREMIUM PAYMENT (Refer to WCIP instruction sheet for state requirements)					YES	NO
23. IS THE PREMIUM FINANCED THROUGH A THIRD PARTY PREMIUM FINANCE COMPANY? IF YES, A COPY OF THE AGREEMENT MUST BE PROVIDED.					<input type="checkbox"/>	<input checked="" type="checkbox"/> N
24. IN APPLICABLE JURISDICTIONS ON QUALIFYING RISKS, IS THE LOSS SENSITIVE RATING PROGRAM (LSRP) CONTINGENCY DEPOSIT BEING PAID IN FULL AT THIS TIME?					<input type="checkbox"/>	<input checked="" type="checkbox"/> N
25. INITIAL OR ESTIMATED ANNUAL DEPOSIT PREMIUM IS REQUIRED IN ORDER TO BIND COVERAGE. THE FOLLOWING PAYMENT METHODS MAY BE USED TO SUBMIT THE REQUIRED INITIAL OR DEPOSIT PREMIUM:						
1. Credit Card (for applications submitted ONLINE at ncci.com ONLY) 2. Electronic funds transfer (EFT) in the form of an Automated Clearing House (ACH) transaction Note: For 1 & 2 above, refer to instructions provided within NCCI's <i>RMAPS® Online Application Service</i> payment screens. All payments by credit card and electronic funds transfer must accompany completed and signed ACORD 130 and 133 forms. 3. Check or Money Order (for MAILED applications ONLY)						
1. ONLY the following types of payment, made payable to NCCI, Inc., are acceptable: a. Checks: Applicant's, Cashier's, Producer's, Finance Company(s) b. Money Order 2. All checks and money orders MUST be made payable to NCCI, Inc., and accompany completed and signed ACORD 130 and 133 forms.						
NO CREDIT CARD OR BANKING INFORMATION SHOULD BE ENTERED ON THE HARDCOPY ACORD 130 or 133 FORMS. A DELAY IN PROCESSING YOUR APPLICATION MAY OCCUR SHOULD THIS INFORMATION BE INCLUDED ON THE SUBMITTED FORMS.						
By submitting this assigned risk workers compensation insurance application, the Applicant authorizes NCCI to debit the account name/number that the undersigned Applicant, or the undersigned Producer on Applicant's behalf, has designated and provided to NCCI, for the amount of this transaction. The Applicant further understands and agrees that all premium transactions and/or premium-related transactions must be processed and accepted by NCCI and the account name/number that the undersigned Applicant, or the undersigned Producer on Applicant's behalf, has designated and provided to NCCI, to be considered received by the Plan Administrator.						

APPLICANT'S STATEMENT

The undersigned Applicant hereby certifies that he/she has read and understands the questions and statements in this application, which is comprised of both the ACORD 130 and ACORD 133 forms. In consideration of coverage being afforded under the applicable Workers Compensation Insurance Plan developed or administered by NCCI (WCIP or Plan), by signing below, the Applicant also certifies that any and/or all responses provided in or to this application, which is comprised of both the ACORD 130 and ACORD 133 forms, are true and accurate and Applicant further understands and agrees that:

- Since he/she has been unable to secure workers compensation coverage in a regular manner through any other insurance carrier or provider, this coverage is being afforded under the applicable WCIP, and that the applicable rates and rating programs charged may be higher than those in the voluntary market.
- Coverage is NOT bound until the completed and signed application is received with the required initial or estimated annual deposit premium and eligibility is determined by the Plan Administrator.
- Provided that Applicant is determined to be eligible and in good faith entitled to WCIP insurance, based upon the information provided herein or otherwise available to the Plan Administrator, coverage will be bound in accordance with WCIP rules. See the WCIP for applicable binding rules.
- In approved jurisdictions, NCCI's Voluntary Coverage Assistance Program (**VCAP® Service**) applies to all employers seeking coverage under the Workers Compensation Insurance Plan, and:
 - Is integrated with and operates as a supplemental program to NCCI's WCIP; and
 - Operates in conjunction with NCCI's Residual Market Application Processing System (**RMAPS® Online Application Service**); and
 - Is designed as a depopulation tool to provide an additional source for producers and employers to secure workers compensation coverage in the voluntary market; and
 - All applications (electronic, phone-in, or mail-in) submitted to the Plan Administrator are reviewed to determine if they meet any of the preselected criteria specified by a participating voluntary carrier; and
 - If the Applicant meets the criteria of an authorized voluntary carrier (**VCAP® User**) and an offer of voluntary coverage is provided, the Applicant, its representative, and/or the producer, must accept a reasonable offer of voluntary coverage in accordance with the WCIP and **VCAP® Service** provisions, and further Applicant will be deemed ineligible for coverage under the WCIP if Applicant does not accept such reasonable offer of voluntary coverage; and
 - If an application does not meet any **VCAP® User's** criteria, the application will continue through NCCI's **RMAPS® Online Application Service**.

If deemed eligible under the WCIP and as further consideration of policy issuance under the WCIP, by signing below, the undersigned Applicant also agrees:

- To maintain a complete record of all payroll transactions in such form as the insurance company may reasonably require and that such record will be available to the company at the designated address; and
- To comply substantially with all laws, orders, rules, and regulations in force and effect issued by the public authorities relating to the welfare, health, and safety of employees; and
- To comply with all reasonable recommendations made by the insurance company relating to the welfare, health, and safety of employees; and
- To take no action in any form to evade the application of an experience rating modification determined in accordance with the applicable experience rating rules, as determined by NCCI, Inc.; and
- To comply with all WCIP rules and procedures and policy terms and conditions, including without limitation, those relating to audits, inspections, loss prevention, and/or premium payments, to maintain WCIP eligibility and coverage.

APPLICANT'S STATEMENT (Continued)**OUTSTANDING BONA FIDE DISPUTE**

The undersigned Applicant also certifies that he/she has no outstanding bona fide dispute as provided in NCCI's WCIP with any producer or company in regard to: (a) payroll records; (b) the amount of premium charged; (c) the payment of premium; (d) the carrying out of any recommendation made for the purpose of safeguarding employees; (e) the handling of any claim or accident report except the following:

LOSS SENSITIVE RATING PLAN (LSRP)

In applicable jurisdictions where the NCCI's Loss Sensitive Rating Plan (LSRP) has been approved for use, the undersigned applicant further understands and agrees that by signing below, I (applicant) acknowledge that the Loss Sensitive Rating Plan (LSRP) has been explained to me, and I agree to be bound by the terms of such plan if my standard premium meets or exceeds the premium eligibility requirement. If these conditions are met, an additional LSRP contingency deposit equal to 20% of standard premium will be required; and

- At the time of application, LSRP has been explained to applicant by the Producer submitting this application on behalf of the applicant; and
- The above referenced additional LSRP contingency deposit is in addition to the initial or deposit premium required in accordance with the WCIP.

RESIDUAL MARKET EXPIRATION LIST (APPLICABLE IN TENNESSEE ONLY)

As provided in T.C.A. 56-5-314(7), a list of employers insured under the Tennessee assigned risk plan is maintained by the Plan Administrator, and made available to interested persons upon request. As part of the application for insurance coverage, the Applicant/employer shall elect whether to be excluded from this list.

THE APPLICANT/INSURED ELECTS TO BE EXCLUDED FROM THE LIST OF EMPLOYERS IN THE TENNESSEE ASSIGNED RISK PLAN: ☐ YES ☐ NO

IMPORTANT NOTE: If on this application the Applicant/employer does not elect to be excluded from the referenced list and the related section for a "Yes" or "No" response is left blank on this application, the Applicant/employer will be deemed to be included in the list of employers insured under the Tennessee assigned risk plan.

APPLICANT COMMUNICATIONS

- By selecting the "Yes" option adjacent to this #1 section, the undersigned Applicant consents and agrees to receive electronically transmitted information and/or communications issued by NCCI by means of electronic mail (email) messages that may contain electronic documents, including without limitation, any binder/verification pages issued by NCCI, and any notifications or other communications as determined by NCCI, to the email address provided by Applicant, or provided by the Producer on Applicant's behalf, to NCCI. ☐ YES ☒ NO
 - If "Yes" to #1 above, provide the valid email address to which the information, notifications and/or communications issued by NCCI should be electronically sent:
-
- By selecting the "Yes" option adjacent to this #3 section, the undersigned Applicant consents and agrees to receive electronically transmitted policy notifications and/or communications issued by the assigned carrier by means of electronic mail (email) messages that may contain electronic documents, including without limitation, any policy documents, cancellations, endorsements, renewal and/or nonrenewal notices, and any other policy notifications and/or communications as determined by the assigned carrier, but only to the extent that the assigned carrier is able and chooses in its discretion to transmit such policy notifications and/or communications electronically to the Applicant. If the assigned carrier is unable or does not choose to transmit such policy notifications and/or communications electronically, then hard copy policy notifications and/or communications will be provided to the Applicant by the assigned carrier as determined by the assigned carrier, subject to any requirements applicable to the assigned carrier under any applicable laws or regulations. Regardless of the undersigned Applicant's selection under this #3 section to receive electronically transmitted policy notifications and/or communications from the assigned carrier, the assigned carrier must comply with any applicable laws or regulations that require a specific method of delivery for policy notifications, documents, or other information, including without limitation, mailing notices of cancellation and/or nonrenewal of policies by certified mail or certificate of mailing. ☐ YES ☒ NO
 - If "Yes" to #3 above, provide the valid email address to which policy notifications and/or communications issued by the assigned carrier should be electronically sent:
-

The undersigned Applicant understands and agrees that by selecting the "Yes" option for #1 and/or #3 above, NCCI and the assigned carrier are authorized, but neither NCCI nor the assigned carrier separately is required or obligated, to electronically transmit any notifications and/or communications referenced in #1 and/or #3 above to the designated email address provided by or on behalf of the Applicant in #2 and/or #4 above, as applicable. By consenting and agreeing to receive such electronically transmitted notifications and/or communications from NCCI and/or the assigned carrier, the undersigned Applicant releases, indemnifies, and holds harmless NCCI and the assigned carrier from any and all claims pertaining to electronically transmitted notifications and/or communications utilizing the Applicant's designated email address as provided to NCCI and/or the assigned carrier by or on behalf of the Applicant in #2 and/or #4 above, as applicable, and including, without limitation, any changes and/or updates to the undersigned Applicant's email address.

The undersigned Applicant further understands and agrees that he/she shall notify NCCI and the assigned carrier of any and all changes and/or updates to Applicant's email, mailing, and/or physical addresses, immediately upon making, implementing, or having knowledge of any such changes and/or updates.

NON-COMPLIANCE WITH AGREEMENTS OR CERTIFICATIONS

The undersigned Applicant further understands and agrees that violation of or non-compliance with any of the above agreements or certifications may result in cancellation of a policy of insurance issued under a Workers Compensation Insurance Plan and/or ineligibility for coverage under a Workers Compensation Insurance Plan.

APPLICANT'S NAME (PRINT OR TYPE) PRIME PAINTERS LLC

SIGNATURE (MUST BE OFFICER, OWNER OR PARTNER)

DATE (MM/DD/YYYY)

REMEMBER: BOTH THE ACORD 130 AND 133 APPLICATIONS MUST BE SIGNED BY THE APPLICANT AND DESIGNATED PRODUCER

PRODUCER COMMUNICATIONS

1. By selecting the "Yes" option adjacent to this #1 section, the undersigned Producer consents and agrees to receive electronically transmitted information and/or communications issued by NCCI by means of electronic mail (email) messages that may contain electronic documents, including without limitation, any binder/verification pages issued by NCCI, and any notifications or other communications as determined by NCCI, to the email address provided by the Producer to NCCI. ☐ Yes ☒ NO
2. If "Yes" to #1 above, provide the valid email address to which the information, notifications and/or communications issued by NCCI should be electronically sent:
3. By selecting the "Yes" option adjacent to this #3 section, the undersigned Producer consents and agrees to receive electronically transmitted policy notifications and/or communications issued by the assigned carrier by means of electronic mail (email) messages that may contain electronic documents, including without limitation, any policy documents, cancellations, endorsements, renewal and/or nonrenewal notices, and any other policy notifications and/or communications as determined by the assigned carrier, but only to the extent that the assigned carrier is able and chooses in its discretion to transmit such policy notifications and/or communications electronically. If the assigned carrier is unable or does not choose to transmit such policy notifications and/or communications electronically, then hard copy policy notifications and/or communications will be provided to the Producer by the assigned carrier as determined by the assigned carrier, subject to any requirements applicable to the assigned carrier under any applicable laws or regulations. Regardless of the undersigned Producer's selection under this #3 section to receive electronically transmitted policy notifications and/or communications from the assigned carrier, the assigned carrier must comply with any applicable laws or regulations that require a specific method of delivery for policy notifications, documents, or other information, including without limitation, mailing notices of cancellation and/or nonrenewal of policies by certified mail or certificate of mailing. ☐ Yes ☒ NO
4. If "Yes" to #3 above, provide the valid email address to which policy notifications and/or communications issued by the assigned carrier should be electronically sent:

The undersigned Producer understands and agrees that by selecting the "Yes" option for #1 and/or #3 above, NCCI and the assigned carrier are authorized, but neither NCCI nor the assigned carrier separately is required or obligated, to electronically transmit any notifications and/or communications referenced in #1 and/or #3 above to the designated email address provided by the Producer in #2 and/or #4 above, as applicable. By consenting and agreeing to receive such electronically transmitted notifications and/or communications from NCCI and/or the assigned carrier, the undersigned Producer releases, indemnifies, and holds harmless NCCI and the assigned carrier from any and all claims pertaining to electronically transmitted notifications and/or communications utilizing the Producer's designated email address as provided to NCCI and/or the assigned carrier by the Producer in #2 and/or #4 above, as applicable, and including, without limitation, any changes and/or updates to the undersigned Producer's email address.

The undersigned Producer further understands and agrees that he/she shall notify NCCI and the assigned carrier of any and all changes and/or updates to Producer's email, mailing, and/or physical addresses, immediately upon making, implementing, or having knowledge of any such changes and/or updates.

PRODUCER'S CERTIFICATION

THE PRODUCER ALSO CERTIFIES THAT HE/SHE HAS BEEN AUTHORIZED TO SUBMIT THE APPLICATION ON BEHALF OF THE APPLICANT AND THAT ALL INFORMATION PROVIDED ON THE ACORD 130 AND 133 IS TRUE AND ACCURATE TO THE BEST OF HIS/HER KNOWLEDGE AND BELIEF.

AGENCY FEIN 58-1294268	AGENCY LICENSE NUMBER 096142	AGENCY PHONE NUMBER (A/C, No, Ext) (770) 717-7380	AGENCY FAX NUMBER (A/C, No) (770) 717-7482
PRODUCER RESIDENT LICENSE NUMBER 497524	STATE GA	EXPIRATION DATE 07/30/2018	PRODUCER NON-RESIDENT LICENSE NUMBER
PRODUCER NAME (PRINT OR TYPE) VICKI NEVILLE			PRODUCER SIGNATURE
E-MAIL ADDRESS: VICKI@FOSTERWITMER.COM			DATE (MM/DD/YYYY)

REMEMBER: BOTH THE ACORD 130 AND 133 APPLICATIONS MUST BE SIGNED BY THE APPLICANT AND DESIGNATED PRODUCER

REMARKS (Attach additional sheets if more space is required)

NCCI APP# 42231500



Residual Market Risk Profile

Printed Date: June 27, 2017

Bound: June 27, 2017

Analyst: TANYA THREATS

Telephone: (800)622-4123

Extension: 1136

Fax: (561)893-4230

Applicant Summary

This Section Provides an overview of the risk information provided on the ACORD 130/133.

Risk Name: PRIME PAINTERS LLC

Entity Type: Limited Liability Corp.

Mailing Address: 1760 SHADY CREEK LN
LAWRENCEVILLE, GA 30043-2709
Telephone: (770)827-1115 Ext:

FEIN: [REDACTED] 4723

Effective Date: 06/15/2017

Governing State: GA

Total Estimated Annual Premium: \$1,620

Deposit Premium: \$1,620

Binder Number: 10-10804-17178-355702

Policy limits: 1,000,000/1,000,000/1,000,000

Includes Non-NCCI States (Y/N): N

Requested Deductible Plan (Y/N): N

Experience Rated Risk (Y/N): N

NCCI Rating ID:

Multi-State Application (Y/N): N

Other Coverages:

None

Type of Business (Existing or New): Existing

Governing Class Code: 5474

Producer Name: FOSTER AND ASSOCIATES DBA FOSTER
WITMER INS AGENCY
Telephone: (770)717-7380 Ext:
Fax Number: (770) 717-7482

Producer FEIN: 58-1294268

Attachments/Edits/Application Journal

This Section indicates attachments and provides an overview of NCCI's analysis of the applicant's information.

A. This section indicates attachments and provides an analysis of the applicant's information.

B. The following documents are attached:

Computer Generated ACORD 130
Computer Generated ACORD 133
ACORD 130
ACORD 133
Inclusion/Exclusion Forms
Outgoing Communication
Other
Premium Calculation Worksheet

C. **The Risk Evaluation System noted the following inconsistencies in the application data provided on the original submission.**

Final Review:

This application indicates that owners/officers have requested to be EXCLUDED from coverage. A signed Exclusion form or letter may be required by the state. Please refer to NCCI's Worker's Compensation Insurance Plan State Pages for more information. Failure to comply with any state requirements regarding signed Exclusion forms may result in additional premium due from the date coverage is effective. [Edit 417]

* Instruction given to producer-> Please select 1 reason

* Response-> a) The producer/employer understands and is aware of the statutory requirements of the state(s) in which this application is requesting coverage and will forward a current copy of the Exclusion letter/form to the carrier and the state if applicable.

Please review and correct the payroll for class code(s) 5474/GA if needed as there is a significant decrease from the most recent audited policy. Further payroll information may be requested in the form of prior tax forms which may result in additional premium due. [Edit 334]

* Instruction given to producer-> Please review the Rating Information section and make any necessary changes to payroll or, if the payroll is correct, please choose from the following:

* Response-> a) Payroll decrease, downsizing

Increased Limits of Liability have been requested. [Edit 21]

Coverage has been requested for the following states: GA [Edit 175]

Officers/LLC Members have elected to be excluded from coverage. [Edit 374]

The Officers/LLC Members require a signed exclusion form. [Edit 378]

CARRIER: Please send the Agent of Record a copy of all items/documentations sent to the insured. [Edit 404]

The Georgia non-cooperation with premium audit endorsement is used to notify an employer that a payroll amount of three times the estimated payroll may be used as a result of failing to cooperate with a workers compensation premium audit. [Edit 406]

Application was processed by producer using the NCCI RMAPS(R) Online Application Service. [Edit 795]

Prior history found, insufficient premium size, this risk is not currently experience rated. [Edit 113]

D. **After searching for the applicant in NCCI's databases, the producer was presented with the following potential matches. If one was chosen, it is marked with an 'X'.**

[X]	PRIME PAINTERS LLC	1760 SHADY CREEK LN	LAWRENCEVILLE	GA	300432709
[]	PRIME PAINTERS LLC	3224 SPARTAN RD	OLNEY	MD	208322343

APPLICATION DIARY:

Date	Action
05/30/2017	Address not Validated Producer Address has not been Validated
05/30/2017	EFFECTIVE DATE Received Date - 05/30/2017 Effective Date - 06/04/2017
06/14/2017	EFFECTIVE DATE Original Effective Date - New Effective Date - 06/15/2017
06/14/2017	Reactivated Application New Effective Date - 06/15/2017
06/19/2017	EFFECTIVE DATE / ARD

	Effective date / ARD has been verified
06/19/2017	NAME OF INSURED Spelling, legal status and/or initials verified
06/19/2017	PRIOR HISTORY No outstanding debts or audits
06/19/2017	STATE SPECIAL N/A, GA
06/19/2017	CLASS CODE Class Code has been verified, 5474 applies to painting
06/19/2017	SPECIAL RULES N/A
06/19/2017	OWNERSHIP/ERM-14 N/A
06/19/2017	Request for Information First Notice Sent Online. Sent Forms: ACORD 130, ACORD 133. 1. If you are receiving this notice then the ACORD forms have not been received. Both ACORD forms are required to continue processing this application. The ACORD 130 and 133 require signatures of BOTH the producer and the applicant. Please fax/upload the signed copies (ALL 8 pages) of the ACORD 130 & 133 forms with BOTH producer and applicant signatures on each application.
06/22/2017	Online Communication Received Please provide all pages of the signed ACORD 130 and ACORD 133 applications. On the ACORD 130, the applicant must initial the privacy statement (if applicable) and both the producer and applicant must sign under the privacy statement. On the ACORD 133, the producer must sign page 4 and the applicant must sign and clearly print their name on page 4. Please attach all pages of the signed ACORD 130 and 133 applications to this email, upload directly in the RMAPS system or fax to the Assigned Risk Analyst. : apps will be uploaded today
06/22/2017	Online Communication Received 1. If you are receiving this notice then the ACORD forms have not been received. Both ACORD forms are required to continue processing this application. The ACORD 130 and 133 require signatures of BOTH the producer and the applicant. Please fax/upload the signed copies (ALL 8 pages) of the ACORD 130 & 133 forms with BOTH producer and applicant signatures on each application.: they will be uploaded today
06/22/2017	Request for Information Second Notice Sent Online. Sent Forms: ACORD 130, ACORD 133. 1. If you are receiving this notice then the ACORD forms have not been received. Both ACORD forms are required to continue processing this application. The ACORD 130 and 133 require signatures of BOTH the producer and the applicant. Please fax/upload the signed copies (ALL 8 pages) of the ACORD 130 & 133 forms with BOTH producer and applicant signatures on each application.
06/22/2017	UPLOADED DOCUMENT RECEIVED A NEW 9 PAGE DOCUMENT "PRIME PAINTERS WC APPS.PDF" HAS BEEN UPLOADED BY ONLINE AGENT
06/23/2017	Phone call

LM for Vicki advised that the signatures were cut off and to please resend the signature pages of the ACORD 130 and 133.

06/26/2017 Request for Information Final Notice Sent Online.
Sent Forms: ACORD 130, ACORD 133. As per my voicemail: 1. If you are receiving this notice then the ACORD forms have not been received. Both ACORD forms are required to continue processing this application. The ACORD 130 and 133 require signatures of BOTH the producer and the applicant. Please fax/upload the signed copies (ALL 8 pages) of the ACORD 130 & 133 forms with BOTH producer and applicant signatures on each application. ** Signature pages were cut off in the submission **

06/26/2017 Phone call
VICKI NEVILLE advised that the signature pages were cut off and that I needed the signature pages that were cut off.

06/27/2017 Online Communication Received
As per my voicemail: 1. If you are receiving this notice then the ACORD forms have not been received. Both ACORD forms are required to continue processing this application. The ACORD 130 and 133 require signatures of BOTH the producer and the applicant. Please fax/upload the signed copies (ALL 8 pages) of the ACORD 130 & 133 forms with BOTH producer and applicant signatures on each application. ** Signature pages were cut off in the submission **: APPS PAGES UPLOADED AGAIN.

06/27/2017 UPLOADED DOCUMENT RECEIVED
A NEW 9 PAGE DOCUMENT "PRIME PAINTERS WC APPS2.PDF" HAS BEEN UPLOADED BY ONLINE AGENT

06/27/2017 IMAGE ASSOCIATION
Images attached and associated correctly

06/27/2017 SIGNED APPLICATION
Verified signatures of the producer and applicant

06/27/2017 VERIFY ADDITIONAL NOTICES
Additional noticed for owner's duties.

06/27/2017 VERIFIED APPLICATION CHANGES
No changes to application

Class Code Selection

Prior Policy History for Named Applicant

This section provides up to five years of historical information on the applicant.

Risk Name: PRIME PAINTERS LLC

Policy Period: 06/07/2016 - 06/04/2017

Address: 1760 SHADY CREEK LANE
 FEIN: [REDACTED] 4723
 NCCI ID:
 VOL/AR: AR
 Legal Status: Other

City: LAWRENCEVILLE
 State: GA
 Zip: 30043
 New/Renew: New
 Multi-State Application (Y/N): N
 Tot. Est. Prem: \$1,448

Exposure Information:

Governing State: GA
 Governing Class: 5474
 Original Estimated Annual Payroll: \$9

Cancellation History:

Date:	Type:	Reason:
06/04/2017	Non-Renewal	

Risk Name: PRIME PAINTERS LLC**Policy Period:** 09/17/2015 - 06/04/2016

Address: 1760 SHADY CREEK LANE
 FEIN: [REDACTED] 4723
 NCCI ID:
 VOL/AR: AR
 Legal Status: Other

City: LAWRENCEVILLE
 State: GA
 Zip: 30043
 New/Renew: Renew
 Multi-State Application (Y/N): N
 Tot. Est. Prem: \$989

Exposure Information:

Governing State: GA
 Governing Class: 5474
 Original Estimated Annual Payroll: \$6

Cancellation History:

Date:	Type:	Reason:
06/04/2016	Non-Renewal	
10/09/2015	Reinstatement	
10/09/2015	Cancellation	FAILURE TO COMPLY WITH THE TERMS & CONDITIONS OR AUDIT FAILURE

Audited Payroll:

Eff Date: 09/17/2015

State:	Class Code:	Payroll:	Premium:
--------	-------------	----------	----------

GA	0900	\$0	\$164
GA	0990	\$0	\$903
GA	5474	\$2	\$1
GA	9740	\$0	\$0
GA	9741	\$0	\$0
GA	9848	\$0	\$85

Risk Name: PRIME PAINTERS LLC**Policy Period:** 06/06/2015 - 06/04/2016**Address:**

2121 PROSPECT WALK WAY

FEIN: [REDACTED] 4723

NCCI ID:

VOL/AR: AR

Legal Status: Other

City:

LAWRENCEVILLE

State:

GA

Zip:

30043

New/Renew: New

Multi-State Application (Y/N): N

Tot. Est. Prem: \$233

Exposure Information:

Governing State: GA

Governing Class: 5474

Original Estimated Annual Payroll: \$12

Cancellation History:**Date:** 08/06/2015**Type:** Cancellation**Reason:**

FAILURE TO COMPLY WITH THE TERMS & CONDITIONS OR AUDIT FAILURE

Audited Payroll:

Eff Date: 06/06/2015

State:	Class Code:	Payroll:	Premium:
GA	0900	\$0	\$38
GA	0990	\$0	\$212
GA	5474	\$4	\$1
GA	9740	\$0	\$0
GA	9741	\$0	\$0
GA	9848	\$0	\$20

Risk Name: PRIME PAINTERS LLC**Policy Period:** 06/04/2014 - 06/04/2015

Address: 2121 PROSPECT WALK WAY
 FEIN: [REDACTED] 4723
 NCCI ID:
 VOL/AR: AR
 Legal Status: Other

City: LAWRENCEVILLE
 State: GA
 Zip: 30043
 New/Renew: Renew
 Multi-State Application (Y/N): N
 Tot. Est. Prem: \$1,390

Exposure Information:

Governing State: GA
 Governing Class: 5474
 Original Estimated Annual Payroll: \$12

Cancellation History:

Date: 06/04/2015
 Type: Non-Renewal
 Reason:

Audited Payroll:

Eff Date: 06/04/2014

State:	Class Code:	Payroll:	Premium:
GA	0900	\$0	\$230
GA	0990	\$0	\$1,269
GA	5474	\$4	\$1
GA	9740	\$0	\$0
GA	9741	\$0	\$0
GA	9848	\$0	\$120

Risk Name: PRIME PAINTERS LLC

Policy Period: 11/25/2013 - 06/04/2014

Address: 2121 PROSPECT WALK WAY
 FEIN: [REDACTED] 4723
 NCCI ID:
 VOL/AR: AR
 Legal Status: Other

City: LAWRENCEVILLE
 State: GA
 Zip: 30043
 New/Renew: Renew
 Multi-State Application (Y/N): N
 Tot. Est. Prem: \$728

Exposure Information:

Governing State: GA
 Governing Class: 5474
 Original Estimated Annual Payroll: \$6

Cancellation History:

Date:	Type:	Reason:
01/19/2014	Reinstatement	
01/19/2014	Cancellation	NONPAYMENT OF PREMIUM

Audited Payroll:

Eff Date: 11/25/2013

State:	Class Code:	Payroll:	Premium:
GA	0900	\$0	\$120
GA	0990	\$0	\$664
GA	5474	\$2	\$1
GA	9740	\$0	\$0
GA	9741	\$0	\$0
GA	9848	\$0	\$63

Risk Name: PRIME PAINTERS LLC**Policy Period:** 06/04/2013 - 06/04/2014

Address:	City:	State:	Zip:
1711 WATFORD GLEN	LAWRENCEVILLE	GA	30043
FEIN: [REDACTED] 4723	New/Renew:	Renew	
NCCI ID:	Multi-State Application (Y/N):	N	
VOL/AR: AR	Tot. Est. Prem:	\$605	
Legal Status: Other			

Exposure Information:

Governing State: GA
 Governing Class: 5474
 Original Estimated Annual Payroll: \$4

Cancellation History:

Date:	Type:	Reason:
11/25/2013	Cancellation	CANCELLED BY EMPLOYER

Audited Payroll:

Eff Date: 06/04/2013

State:	Class Code:	Payroll:	Premium:
GA	0900	\$0	\$110

GA	0990	\$0	\$604
GA	5474	\$4	\$1
GA	9740	\$0	\$0
GA	9741	\$0	\$0

Additional History

This Section provides, if applicable, experience modification, inspection, and any additional classification information.

Prior Policy History for Other Named Insured(s)

This section provides up to five years of historical information on all related entities.

Additional History for Other Named Insured(s)

This section provides, if applicable, experience modification, inspection, and any other classification information.

Related Entities

This section lists the name(s) of those entities related to the applicant who are not requesting coverage

Criteria set used: GA/03-Jan-2000 08:00:00 Global/03-Jan-2000 07:00:00 Application ID# 42231500

NOTICE TO ALL ASSIGNED CARRIERS:

By receipt of the above, the assigned carrier certifies that the information provided on the risk profile shall be used for the specific purpose of providing workers compensation insurance to this applicant pursuant to, and in accordance with the state Workers Compensation Insurance Plan requirements. NCCI makes no representation or warranty, expressed or implied, as to any matter whatsoever, including but not limited to the accuracy of any information, product, or service furnished hereunder. The recipient of this material subscribes to and uses the information "as is" and is subject to any license agreement which governs the use of this information.



PREMIUM CALCULATOR WORKSHEET

RISK NAME: PRIME PAINTERS LLC
EFFECTIVE DATE: 06/15/2017
BINDER NUMBER: 10-10804-17178-355702
APPLICATION ID NUMBER: 42231500
GOVERNING STATE: Georgia
GOVERNING CLASS CODE: 5474
ANNIVERSARY RATING DATE: N/A
EXPERIENCE RATING DATE: N/A
PREMIUM PERIOD: 06/15/2017 - 06/15/2018

SUMMARY INFORMATION

STATE NAME	ESTIMATED ANNUAL PREMIUM
Georgia	1,620
<hr/>	
SUBTOTAL FOR TERRORISM PREMIUM - ALL STATE(S):**** (GA) \$0.00 = \$0.00	INCL
<hr/>	
ESTIMATED ANNUAL PREMIUM	1,620
DEPOSIT PERCENTAGE:	100%
DEPOSIT PREMIUM:	1,620
GEORGIA INSOLVENCY POOL ASSESSMENT	0
TOTAL DEPOSIT PREMIUM	1,620
TOTAL ESTIMATED ANNUAL PREMIUM	1,620
TOTAL PREMIUM PAID	1,620

**** See Individual state worksheet(s) that accompany the summary page for explanation.

Risk Name: PRIME PAINTERS LLC
EFFECTIVE DATE: 06/15/2017
STATE: Georgia

Employee Information:

Class Code:	Suffix:	No of Employees	Total Payroll	Rate	Calculated Premium	Minimum Premium
5474		0	0	38.83	0	1500

Executive Officer Information:

Name	INC/ EXC	Class Code:	Title	Salary	Calculated Salary	Rate	Calculated Premium	Minimum Premium
SUIUGAN, EMIL	E	5474	MEMBER	56,300	0	0.00	0	1500

INCREASED LIMITS(1000000/1000000/1000000)(1.1)	+	120
SUBJECT PREMIUM	=	120
TOTAL MODIFIED PREMIUM	=	120
MERIT RATING(-12.5)	+/-	-15
STANDARD PREMIUM	=	105
EXPENSE CONSTANT	+	160

TERRORISM MISC. VALUE BY STATE (.02)	\$0.00	INCL
SUBTOTAL FOR TERRORISM PREMIUM *****	\$0.00	INCL
ESTIMATED ANNUAL PREMIUM	=	1620

***** Subtotal for Terrorism Premium: For insured losses resulting from certified acts of terrorism as determined under the Terrorism Risk Insurance Act of 2002, and any amendments, including as amended and extended by the Terrorism Risk Insurance Program Reauthorization Act of 2015, and applied consistent with NCCI manual rules and forms (Terrorism Misc. Value or Terrorism Rate by State).



MERIT RATING WORKSHEET

Risk Name: PRIME PAINTERS LLC
EFFECTIVE DATE: 15-JUN-17
APPLICATION ID NUMBER: 42231500
GOVERNING STATE: Georgia
ANNIVERSART RATING DATE: 15-JUN-17
PREMIUM PERIOD: 15-JUN-17 - 15-JUN-18

MERIT RATING STATES

STATE NAME Georgia

GEORGIA MERIT RATING

This form provides prior claims information of a Georgia employer whose annual premium is less than the amount necessary to qualify for experience rating. The Georgia Merit Rating Plan shall be based upon the number of claims (lost time) of the insured during the most recent one (1) year period for which statistics are available. This one (1) year period is that which would otherwise be used for experience rating purposes. Minimum premium applications do not qualify for Merit Rating.

Insured Name: PRIME PAINTERS LLC

Application Id: 42231500

Policy effective date: 15-JUN-17

Number of claims for most recent year: Year 2015 # of claims 0

Number of claims for the next most recent year: Year N/A # of claims N/A

Number of claims for the third most recent year: Year N/A # of claims N/A

The following debit or credit shall be applied: -12.5% credit



WORKERS COMPENSATION APPLICATION

DATE (MM/DD/YYYY)

06/14/2017

AGENCY NAME AND ADDRESS FOSTER AND ASSOCIATES DBA FOSTER WITMER INS AGENCY 3100 BRECKINRIDGE BLVD STE 510 DULUTH,GA 30096-7507		COMPANY: UNDERWRITER: APPLICANT NAME: PRIME PAINTERS LLC OFFICE PHONE: (770) 827-1115 MOBILE PHONE: MAILING ADDRESS (Including Zip + 4) 1760 SHADY CREEK LN LAWRENCEVILLE,GA 30043-2709 E-MAIL ADDRESS: VICKI@FOSTERWITMER.COM		YRS IN BUS: 10 SIC: NAICS: Website Address:	
PRODUCER NAME: VICKI NEVILLE CS REPRESENTATIVE VICKI NEVILLE NAME: OFFICE PHONE (770) 717-7380 (A/C. No. Ext): MOBILE PHONE: FAX (A/C.NO): (770) 717-7482 EMAIL ADDRESS: VICKI@FOSTERWITMER.COM CODE: SUB CODE: AGENCY CUSTOMER ID:		SOLE PROPRIETOR CORPORATION X LLC PARTNERSHIP SUBCHAPTER "S" CORP JOINT VENTURE TRUST UNINCORPORATED ASSOCIATION OTHER CREDIT BUREAU NAME: FEDERAL EMPLOYER ID NUMBER NCCI RISK ID NUMBER: ID NUMBER: OTHER RATING BUREAU ID EMPLOYER REGISTRATION NUMBER OR STATE		4723	

STATUS OF SUBMISSION

BILLING / AUDIT INFORMATION

<input type="checkbox"/> QUOTE	<input type="checkbox"/> ISSUE POLICY	<input type="checkbox"/> BILLING PLAN	<input type="checkbox"/> PAYMENT PLAN	<input type="checkbox"/> AUDIT
<input type="checkbox"/> BOUND (Give date and/or attach copy)	<input type="checkbox"/> AGENCY BILL	<input type="checkbox"/> ANNUAL	<input type="checkbox"/> OTHER:	<input type="checkbox"/> AT EXPIRATION
<input checked="" type="checkbox"/> ASSIGNED RISK (Attach ACORD 133)	<input type="checkbox"/> DIRECT BILL	<input type="checkbox"/> SEMI-ANNUAL	<input type="checkbox"/> QUARTERLY	<input type="checkbox"/> MONTHLY
		<input type="checkbox"/> QUARTERLY	<input type="checkbox"/> % DOWN:	<input type="checkbox"/> QUARTERLY

LOCATIONS

LOC #	Highest Floor	STREET, CITY, COUNTY, STATE, ZIP CODE
1		1760 SHADY CREEK LN LAWRENCEVILLE,GA 30043-2709

POLICY INFORMATION

PROPOSED EFF DATE 6/15/2017		PROPOSED EXP DATE 6/15/2018		NORMAL ANNIVERSARY RATING DATE		PARTICIPATING NON-PARTICIPATING		RETRO PLAN	
PART 1 - WORKERS COMPENSATION (States)		PART 2 - EMPLOYER'S LIABILITY		PART 3 - OTHER STATES INS		DEDUCTIBLES (N / A in WI)		AMOUNT / % (N / A in WI)	
GA		\$ 1,000,000 EACH ACCIDENT \$ 1,000,000 DISEASE-POLICY LIMIT \$ 1,000,000 DISEASE-EACH EMPLOYEE				MEDICAL INDEMNITY		OTHER COVERAGES U.S.L. & H. VOLUNTARY COMP FOREIGN COV MANAGED CARE	
DIVIDEND PLAN/SAFETY GROUP		ADDITIONAL COMPANY INFORMATION							
SPECIFY ADDITIONAL COVERAGES / ENDORSEMENTS (Attach ACORD 101, Additional Remarks Schedule, if more space is required)									

TOTAL ESTIMATED ANNUAL PREMIUM - ALL STATES

TOTAL ESTIMATED ANNUAL PREMIUM ALL STATES \$1,620.00	TOTAL MINIMUM PREMIUM ALL STATES \$0.00	TOTAL DEPOSIT PREMIUM ALL STATES \$1,620.00
---	--	--

CONTACT INFORMATION

TYPE	NAME	OFFICE PHONE	MOBILE PHONE	E-MAIL
INSPECTION	EMIL SUIUGAN	(770) 827-1115		
ACCTING RECORD	EMIL SUIUGAN	(770) 827-1115		
CLAIMS INFO	EMIL SUIUGAN	(770) 827-1115		

INDIVIDUALS INCLUDED / EXCLUDED

PARTNERS, OFFICERS, RELATIVES (Must be employed by business operations) TO BE INCLUDED OR EXCLUDED (Remuneration/Payroll to be included must be part of rating information section.)
 Exclusions in Missouri must meet the requirements of Section 287.090 RSMo.

STATE	LOC #	NAME	DATE OF BIRTH	TITLE/ RELATIONSHIP	OWNER-SHIP %	DUTIES	INC/EXC	CLASS CODE	REMUNERATION/ PAYROLL
GA		SUIUGAN, EMIL	06/20/1979	MEMBER	100	OWNER/OPERATOR	E	5474	56300

AGENCY CUSTOMER ID: _____

STATE RATING SHEET # 1 OF 1 SHEETS

STATE RATING WORKSHEET

FOR MULTIPLE STATES, ATTACH AN ADDITIONAL PAGE 2 OF THIS FORM

RATING INFORMATION - STATE: Georgia

LOC #	CLASS CODE	DESCR CODE	CATEGORIES, DUTIES, CLASSIFICATIONS	# EMPLOYEES FULL TIME	PART TIME	SIC	NAICS	ESTIMATED ANNUAL REMUNERATION/ PAYROLL	RATE	ESTIMATED ANNUAL MANUAL PREMIUM
1	5474		PAINTING NOC SHOP OPERATIONS DRIVERS	0				0	38.83	0

PREMIUM

STATE:	FACTOR	FACTORED PREMIUM		FACTOR	FACTORED PREMIUM
TOTAL	N / A	\$0			\$0
INCREASED LIMITS		\$120.00	SCHEDULE RATING *		\$0
DEDUCTIBLE *	0	\$0	CCPAP		
			STANDARD PREMIUM		\$105.00
EXPERIENCE OR MERIT MODIFICATION	0	\$0	PREMIUM DISCOUNT		\$0.00
		\$0	EXPENSE CONSTANT	N / A	\$160.00
ASSIGNED RISK SURCHARGE *	0	\$0.00	TAXES / ASSESSMENTS *	N / A	\$0.00
ARAP *	0.00	\$0.00			\$0
* N / A in Wisconsin					
TOTAL ESTIMATED ANNUAL PREMIUM		MINIMUM PREMIUM		DEPOSIT PREMIUM	
\$1,620.00		\$1,620.00			

REMARKS (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)

NCCI APP# 42231500

AGENCY CUSTOMER ID: _____

PRIOR CARRIER INFORMATION / LOSS HISTORY

PROVIDE INFORMATION FOR THE PAST 5 YEARS AND USE THE REMARKS SECTION FOR LOSS DETAILS						LOSS RUN ATTACHED	
YEAR	CARRIER & POLICY NUMBER	ANNUAL PREMIUM	MOD	# CLAIMS	AMOUNT PAID	RESERVE	
	CO:						
	POL #:						
	CO:						
	POL #:						
	CO:						
	POL #:						
	CO:						
	POL #:						
	CO:						
	POL #:						

NATURE OF BUSINESS / DESCRIPTION OF OPERATIONS

GIVE COMMENTS AND DESCRIPTIONS OF BUSINESS, OPERATIONS AND PRODUCTS: MANUFACTURING - RAW MATERIALS, PROCESSES, PRODUCT, EQUIPMENT; CONTRACTOR - TYPE OF WORK, SUB-CONTRACTS; MERCANTILE - MERCHANDISE, CUSTOMERS, DELIVERIES; SERVICE - TYPE, LOCATION; FARM - ACREAGE, ANIMALS, MACHINERY, SUB-CONTRACTS.

PAINTING

GENERAL INFORMATION

EXPLAIN ALL "YES" RESPONSES	Y / N
1. DOES APPLICANT OWN, OPERATE OR LEASE AIRCRAFT / WATERCRAFT?	N
2. DO / HAVE PAST, PRESENT OR DISCONTINUED OPERATIONS INVOLVE(D) STORING, TREATING, DISCHARGING, APPLYING, DISPOSING, OR TRANSPORTING OF HAZARDOUS MATERIAL? (e.g. landfills, wastes, fuel tanks, etc)	N
3. ANY WORK PERFORMED UNDERGROUND OR ABOVE 15 FEET?	N
4. ANY WORK PERFORMED ON BARGES, VESSELS, DOCKS, BRIDGE OVER WATER?	N
5. IS APPLICANT ENGAGED IN ANY OTHER TYPE OF BUSINESS?	N
6. ARE SUB-CONTRACTORS USED? (If "YES", give % of work subcontracted)	N
7. ANY WORK SUBLET WITHOUT CERTIFICATES OF INSURANCE? (If "YES", payroll for this work must be included in the State Rating Worksheet on Page 2)	N
8. IS A WRITTEN SAFETY PROGRAM IN OPERATION?	N
9. ANY GROUP TRANSPORTATION PROVIDED?	N
10. ANY EMPLOYEES UNDER 16 OR OVER 60 YEARS OF AGE?	N
11. ANY SEASONAL EMPLOYEES?	N
12. IS THERE ANY VOLUNTEER OR DONATED LABOR? (If "YES", please specify)	N
13. ANY EMPLOYEES WITH PHYSICAL HANDICAPS?	N
14. DO EMPLOYEES TRAVEL OUT OF STATE? (If "YES", indicate state(s) of travel and frequency)	N
15. ARE ATHLETIC TEAMS SPONSORED?	N
16. ARE PHYSICALS REQUIRED AFTER OFFERS OF EMPLOYMENT ARE MADE?	N

AGENCY CUSTOMER ID: _____

GENERAL INFORMATION (continued)

EXPLAIN ALL "YES" RESPONSES	Y / N
17. ANY OTHER INSURANCE WITH THIS INSURER?	N
18. ANY PRIOR COVERAGE DECLINED / CANCELLED / NON-RENEWED IN THE LAST THREE (3) YEARS? (Missouri Applicants – Do not answer this question) CURRENT CARRIER NON RENEWED NO LONGER WRITING IN GEORGIA	Y
19. ARE EMPLOYEE HEALTH PLANS PROVIDED?	N
20. DO ANY EMPLOYEES PERFORM WORK FOR OTHER BUSINESSES OR SUBSIDIARIES?	N
21. DO YOU LEASE EMPLOYEES TO OR FROM OTHER EMPLOYERS?	N
22. DO ANY EMPLOYEES PREDOMINANTLY WORK AT HOME? If "YES", # of Employees: _____	N
23. ANY TAX LIENS OR BANKRUPTCY WITHIN THE LAST FIVE (5) YEARS? (If "YES", please specify)	N
24. ANY UNDISPUTED AND UNPAID WORKERS COMPENSATION PREMIUM DUE FROM YOU OR ANY COMMONLY MANAGED OR OWNED ENTERPRISES? (If "YES", explain including entity name(s) and policy number(s))	N

SIGNATURE

Copy of the Notice of Information Practices (Privacy) has been given to the applicant. (Not required in all states, contact your agent or broker for your state's requirements.)			
<p>PERSONAL INFORMATION ABOUT YOU, INCLUDING INFORMATION FROM A CREDIT OR OTHER INVESTIGATIVE REPORT, MAY BE COLLECTED FROM PERSONS OTHER THAN YOU IN CONNECTION WITH THIS APPLICATION FOR INSURANCE AND SUBSEQUENT AMENDMENTS AND RENEWALS. SUCH INFORMATION AS WELL AS OTHER PERSONAL AND PRIVILEGED INFORMATION COLLECTED BY US OR OUR AGENTS MAY IN CERTAIN CIRCUMSTANCES BE DISCLOSED TO THIRD PARTIES WITHOUT YOUR AUTHORIZATION. CREDIT SCORING INFORMATION MAY BE USED TO HELP DETERMINE EITHER YOUR ELIGIBILITY FOR INSURANCE OR THE PREMIUM YOU WILL BE CHARGED. WE MAY USE A THIRD PARTY IN CONNECTION WITH THE DEVELOPMENT OF YOUR SCORE. YOU MAY HAVE THE RIGHT TO REVIEW YOUR PERSONAL INFORMATION IN OUR FILES AND REQUEST CORRECTION OF ANY INACCURACIES. YOU MAY ALSO HAVE THE RIGHT TO REQUEST IN WRITING THAT WE CONSIDER EXTRAORDINARY LIFE CIRCUMSTANCES IN CONNECTION WITH THE DEVELOPMENT OF YOUR CREDIT SCORE. THESE RIGHTS MAY BE LIMITED IN SOME STATES. PLEASE CONTACT YOUR AGENT OR BROKER TO LEARN HOW THESE RIGHTS MAY APPLY IN YOUR STATE OR FOR INSTRUCTIONS ON HOW TO SUBMIT A REQUEST TO US FOR A MORE DETAILED DESCRIPTION OF YOUR RIGHTS AND OUR PRACTICES REGARDING PERSONAL INFORMATION. (Not applicable in AZ, CA, DE, KS, MA, MN, ND, NY, OR, VA, or WV. Specific ACORD 38s are available for applicants in these states.) (Applicant's Initials): <u>DBS</u></p>			
<p>Applicable in AL, AR, DC, LA, MD, NM, RI and WV: Any person who knowingly (or willfully)* presents a false or fraudulent claim for payment of a loss or benefit or knowingly (or willfully)* presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. *Applies in MD Only.</p> <p>Applicable in CO: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.</p> <p>Applicable in FL and OK: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony (of the third degree)*. *Applies in FL Only.</p> <p>Applicable in KS: Any person who, knowingly and with intent to defraud, presents, causes to be presented or prepares with knowledge or belief that it will be presented to or by an insurer, purported insurer, broker or any agent thereof, any written statement as part of, or in support of, an application for the issuance of, or the rating of an insurance policy for personal or commercial insurance, or a claim for payment or other benefit pursuant to an insurance policy for commercial or personal insurance which such person knows to contain materially false information concerning any fact material thereto; or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act.</p> <p>Applicable in KY, NY, OH and PA: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties (not to exceed five thousand dollars and the stated value of the claim for each such violation)*. *Applies in NY Only.</p> <p>Applicable in ME, TN, VA and WA: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties (may)* include imprisonment, fines and denial of insurance benefits. *Applies in ME Only.</p> <p>Applicable in NJ: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.</p> <p>Applicable in OR: Any person who knowingly and with intent to defraud or solicit another to defraud the insurer by submitting an application containing a false statement as to any material fact may be violating state law.</p> <p>Applicable in PR: Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation by a fine of not less than five thousand dollars (\$5,000) and not more than ten thousand dollars (\$10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances [be] present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.</p> <p>Applicable in UT: Any person who knowingly presents false or fraudulent underwriting information, files or causes to be filed a false or fraudulent claim for disability compensation or medical benefits, or submits a false or fraudulent report or billing for health care fees or other professional services is guilty of a crime and may be subject to fines and confinement in state prison.</p>			
THE UNDERSIGNED IS AN AUTHORIZED REPRESENTATIVE OF THE APPLICANT AND REPRESENTS THAT REASONABLE INQUIRY HAS BEEN MADE TO OBTAIN THE ANSWERS TO QUESTIONS ON THIS APPLICATION. HE/SHE REPRESENTS THAT THE ANSWERS ARE TRUE, CORRECT AND COMPLETE TO THE BEST OF HIS/HER KNOWLEDGE.			
APPLICANT'S SIGNATURE (Must be Officer, Owner or Partner)	DATE	PRODUCER'S SIGNATURE	NATIONAL PRODUCER NUMBER
	6/15/2017		

AGENCY CUSTOMER ID: _____



WORKERS COMPENSATION INSURANCE PLAN ASSIGNED RISK SECTION

 DATE (MM/DD/YYYY)
06/14/2017

THIS FORM ALONG WITH AN ACORD 130 WORKERS COMPENSATION APPLICATION CONSTITUTE AN APPLICATION FOR WORKERS COMPENSATION INSURANCE PLAN (ASSIGNED RISK) COVERAGE. THIS FORM MUST BE ATTACHED TO AN ACORD 130 FOR SUBMISSION. PLEASE REFER TO THE STATE SPECIFIC INSTRUCTIONS PAGE FOR SPECIFIC REQUIREMENTS.

 APPLICANT NAME
PRIME PAINTERS LLC

 PROPOSED EFF DATE
06/15/2017

SUPPLEMENTAL INFORMATION

PAYROLL OFFICE NAME, ADDRESS AND TELEPHONE NUMBER (A PO BOX ADDRESS ALONE IS NOT ACCEPTABLE. PLEASE PROVIDE DRIVING INSTRUCTIONS IF A ROUTE ADDRESS IS SHOWN.)

EMIL SUIUGAN
1760 SHADY CREEK LN
LAWRENCEVILLE, GA 30043-2709

STATE DEVELOPING HIGHEST PAYROLL: GA

EXPLAIN ALL "YES" RESPONSES IN THE REMARKS SECTION

	YES	NO																								
1. HAS THERE BEEN PREVIOUS WORKERS COMPENSATION COVERAGE: IN THIS STATE? IN ANY OTHER STATE? -IF NO TO BOTH QUESTIONS, WAS THIS DUE TO: <input type="checkbox"/> NEW BUSINESS <input type="checkbox"/> SELF INSURED-INDEP <input type="checkbox"/> SELF INSURED-GROUP <input type="checkbox"/> # EMPLOYEES	<input type="checkbox"/> Y <input type="checkbox"/>	<input type="checkbox"/> N <input type="checkbox"/>																								
2. IS THERE ANY UNPAID WORKERS COMPENSATION PREMIUM DUE OR IN DISPUTE FROM YOU OR ANY COMMONLY MANAGED OR OWNED ENTERPRISES? IF YES, EXPLAIN INCLUDING ENTITY NAME(S) AND POLICY NUMBER(S).	<input type="checkbox"/>	<input type="checkbox"/> N																								
3. YEAR APPLICANT'S BUSINESS BEGAN: 2007																										
4. HAS THERE BEEN A NAME CHANGE, CONSOLIDATION, MERGER ACQUISITION, SALE, PURCHASE OR TRANSFER OF ASSETS OR OWNERSHIP CHANGE DURING THE PAST FIVE (5) YEARS? IF YES, PROVIDE A COMPLETED ERM-14 FORM.	<input type="checkbox"/>	<input type="checkbox"/> N																								
5. IS APPLICANT RELATED THROUGH COMMON MANAGEMENT OR OWNERSHIP TO ANY ENTITY NOT LISTED ON THE ACORD 130 FORM, WHETHER COVERAGE IS REQUIRED OR NOT? IF YES, PROVIDE A COMPLETED ERM-14 FORM.	<input type="checkbox"/>	<input type="checkbox"/> N																								
6. DO YOU LEASE WORKERS FROM A PROFESSIONAL EMPLOYER ORGANIZATION (PEO)? IF YES, REFER TO WCIP INSTRUCTIONS. NAME OF PROFESSIONAL EMPLOYER ORGANIZATION (PEO): _____	<input type="checkbox"/>	<input type="checkbox"/> N																								
7. DO YOU LEASE WORKERS TO A CLIENT COMPANY? IF YES, REFER TO WCIP INSTRUCTIONS.	<input type="checkbox"/>	<input type="checkbox"/> N																								
8. ARE YOU SEEKING TO COVER THE LEASED WORKERS? IF YES, REFER TO WCIP INSTRUCTIONS.	<input type="checkbox"/>	<input type="checkbox"/> N																								
9. DO YOU PROVIDE TEMPORARY ARRANGEMENT SERVICES TO OTHER EMPLOYERS? IF YES, PROVIDE A TEMPORARY LABOR CONTRACTOR EMPLOYEE FORM.	<input type="checkbox"/>	<input type="checkbox"/> N																								
10. DO YOU HAVE A FRANCHISE OR LICENSING AGREEMENT? IF YES, PROVIDE A COPY OF THE AGREEMENT.	<input type="checkbox"/>	<input type="checkbox"/> N																								
11. IS COVERAGE REQUESTED FOR A SPORTS TEAM? IF YES, PROVIDE NAME OF SPORTS TEAM AND DOMICILED STATE. NAME OF SPORTS TEAM: _____ DOMICILED STATE: _____	<input type="checkbox"/>	<input type="checkbox"/> N																								
12. DO TRUCKING CLASSIFICATIONS APPLY? IF YES, COMPLETE QUESTIONS 13 - 20.	<input type="checkbox"/>	<input type="checkbox"/> N																								
13. DO YOU OR YOUR EMPLOYEES REGULARLY OPERATE FROM A BASE TERMINAL(S) WHICH IS (ARE) USED TO LOAD, UNLOAD, STORE OR TRANSFER FREIGHT? IF YES, PLEASE PROVIDE A LIST OF TERMINAL ADDRESSES:	<input type="checkbox"/>	<input type="checkbox"/>																								
<table border="1"> <thead> <tr> <th>#</th> <th>STREET</th> <th>CITY</th> <th>COUNTY</th> <th>ST</th> <th>ZIP CODE</th> </tr> </thead> <tbody> <tr> <td>1</td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>2</td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>3</td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> </tbody> </table>	#	STREET	CITY	COUNTY	ST	ZIP CODE	1						2						3							
#	STREET	CITY	COUNTY	ST	ZIP CODE																					
1																										
2																										
3																										
14. CAN EACH DRIVER'S STATE OF MAJORITY DRIVING TIME BE ESTABLISHED THROUGH VERIFIABLE RECORDS OR LOGS?	<input type="checkbox"/>	<input type="checkbox"/>																								
15. PLEASE PROVIDE A LIST OF ALL DRIVERS/HELPERS AND THEIR STATE OF RESIDENCE:																										
<table border="1"> <thead> <tr> <th></th> <th>DRIVER NAME</th> <th>TERMINAL # (SEE ABOVE)</th> <th>MAJORITY DRIVING STATE</th> <th>RESIDENCE STATE</th> </tr> </thead> <tbody> <tr> <td>1</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>2</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>3</td> <td></td> <td></td> <td></td> <td></td> </tr> </tbody> </table>		DRIVER NAME	TERMINAL # (SEE ABOVE)	MAJORITY DRIVING STATE	RESIDENCE STATE	1					2					3										
	DRIVER NAME	TERMINAL # (SEE ABOVE)	MAJORITY DRIVING STATE	RESIDENCE STATE																						
1																										
2																										
3																										
16. WHAT TYPE(S) OF GOODS ARE BEING HAULED? (e.g., coal, dry goods, explosives, scaffolding, water / waste fluids from oil field sites, etc.)																										
17. DO YOU OWN THESE GOODS?	<input type="checkbox"/>	<input type="checkbox"/>																								
18. IS APPLICANT UNDER EXCLUSIVE CONTRACT WITH ANY RETAIL STORE(S)? IF YES, PROVIDE COPY OF CONTRACT(S).	<input type="checkbox"/>	<input type="checkbox"/>																								
19. IS APPLICANT UNDER EXCLUSIVE CONTRACT WITH ANY POSTAL SERVICE? IF YES, PROVIDE COPY OF CONTRACT(S).	<input type="checkbox"/>	<input type="checkbox"/>																								
20. WITHIN WHAT MILE RADIUS IS HAULING DONE? # MILES: _____																										

AGENCY CUSTOMER ID: _____

INSURANCE COMPANIES WHO HAVE OFFERED/REFUSED INSURANCE					YES	NO
21. HAVE YOU RECEIVED ANY OFFERS OF VOLUNTARY COVERAGE? (INCLUDE MULTI-LINE OR RETROSPECTIVE RATING PLAN, IF APPLICABLE) IF YES, PROVIDE FULL DETAILS INCLUDING PLAN TERMS IN THE REMARKS SECTION.					<input type="checkbox"/>	<input checked="" type="checkbox"/> N
22. INDICATE THE NUMBER OF INSURANCE COMPANIES WHICH HAVE REFUSED THE APPLICANT COVERAGE IN THE LAST 60 DAYS (OR IN ACCORDANCE WITH STATE SPECIFIC GUIDELINES): 4						
LIST COMPANY NAMES, REPRESENTATIVE NAMES, TELEPHONE NUMBERS AND DATES OF REFUSALS. REFER TO WCIP TO VERIFY REQUIREMENTS.						
COMPANY NAME	REPRESENTATIVE NAME	TELEPHONE NUMBER	DATE OF REFUSAL	COMMENTS		
PREMIUM PAYMENT (Refer to WCIP instruction sheet for state requirements)					YES	NO
23. IS THE PREMIUM FINANCED THROUGH A THIRD PARTY PREMIUM FINANCE COMPANY? IF YES, A COPY OF THE AGREEMENT MUST BE PROVIDED.					<input type="checkbox"/>	<input checked="" type="checkbox"/> N
24. IN APPLICABLE JURISDICTIONS ON QUALIFYING RISKS, IS THE LOSS SENSITIVE RATING PROGRAM (LSRP) CONTINGENCY DEPOSIT BEING PAID IN FULL AT THIS TIME?					<input type="checkbox"/>	<input checked="" type="checkbox"/> N
25. INITIAL OR ESTIMATED ANNUAL DEPOSIT PREMIUM IS REQUIRED IN ORDER TO BIND COVERAGE. THE FOLLOWING PAYMENT METHODS MAY BE USED TO SUBMIT THE REQUIRED INITIAL OR DEPOSIT PREMIUM:						
1. Credit Card (for applications submitted ONLINE at nccl.com ONLY) 2. Electronic funds transfer (EFT) in the form of an Automated Clearing House (ACH) transaction Note: For 1 & 2 above, refer to instructions provided within NCCI's <i>RMAPS® Online Application Service</i> payment screens. All payments by credit card and electronic funds transfer must accompany completed and signed ACORD 130 and 133 forms. 3. Check or Money Order (for MAILED applications ONLY)						
1. ONLY the following types of payment, made payable to NCCI, Inc., are acceptable: a. Checks: Applicant's, Cashier's, Producer's, Finance Company(s) b. Money Order 2. All checks and money orders MUST be made payable to NCCI, Inc., and accompany completed and signed ACORD 130 and 133 forms.						
NO CREDIT CARD OR BANKING INFORMATION SHOULD BE ENTERED ON THE HARDCOPY ACORD 130 or 133 FORMS. A DELAY IN PROCESSING YOUR APPLICATION MAY OCCUR SHOULD THIS INFORMATION BE INCLUDED ON THE SUBMITTED FORMS.						
By submitting this assigned risk workers compensation insurance application, the Applicant authorizes NCCI to debit the account name/number that the undersigned Applicant, or the undersigned Producer on Applicant's behalf, has designated and provided to NCCI, for the amount of this transaction. The Applicant further understands and agrees that all premium transactions and/or premium-related transactions must be processed and accepted by NCCI and the account name/number that the undersigned Applicant, or the undersigned Producer on Applicant's behalf, has designated and provided to NCCI, to be considered received by the Plan Administrator.						

APPLICANT'S STATEMENT

The undersigned Applicant hereby certifies that he/she has read and understands the questions and statements in this application, which is comprised of both the ACORD 130 and ACORD 133 forms. In consideration of coverage being afforded under the applicable Workers Compensation Insurance Plan developed or administered by NCCI (WCIP or Plan), by signing below, the Applicant also certifies that any and/or all responses provided in or to this application, which is comprised of both the ACORD 130 and ACORD 133 forms, are true and accurate and Applicant further understands and agrees that:

- Since he/she has been unable to secure workers compensation coverage in a regular manner through any other insurance carrier or provider, this coverage is being afforded under the applicable WCIP, and that the applicable rates and rating programs charged may be higher than those in the voluntary market.
- Coverage is NOT bound until the completed and signed application is received with the required initial or estimated annual deposit premium and eligibility is determined by the Plan Administrator.
- Provided that Applicant is determined to be eligible and in good faith entitled to WCIP insurance, based upon the information provided herein or otherwise available to the Plan Administrator, coverage will be bound in accordance with WCIP rules. See the WCIP for applicable binding rules.
- In approved jurisdictions, NCCI's Voluntary Coverage Assistance Program (**VCAP® Service**) applies to all employers seeking coverage under the Workers Compensation Insurance Plan, and:
 - Is integrated with and operates as a supplemental program to NCCI's WCIP; and
 - Operates in conjunction with NCCI's Residual Market Application Processing System (**RMAPS® Online Application Service**); and
 - Is designed as a depopulation tool to provide an additional source for producers and employers to secure workers compensation coverage in the voluntary market; and
 - All applications (electronic, phone-in, or mail-in) submitted to the Plan Administrator are reviewed to determine if they meet any of the preselected criteria specified by a participating voluntary carrier; and
 - If the Applicant meets the criteria of an authorized voluntary carrier (**VCAP® User**) and an offer of voluntary coverage is provided, the Applicant, its representative, and/or the producer, must accept a reasonable offer of voluntary coverage in accordance with the WCIP and **VCAP® Service** provisions, and further Applicant will be deemed ineligible for coverage under the WCIP if Applicant does not accept such reasonable offer of voluntary coverage; and
 - If an application does not meet any **VCAP® User's** criteria, the application will continue through NCCI's **RMAPS® Online Application Service**.

If deemed eligible under the WCIP and as further consideration of policy issuance under the WCIP, by signing below, the undersigned Applicant also agrees:

- To maintain a complete record of all payroll transactions in such form as the insurance company may reasonably require and that such record will be available to the company at the designated address; and
- To comply substantially with all laws, orders, rules, and regulations in force and effect issued by the public authorities relating to the welfare, health, and safety of employees; and
- To comply with all reasonable recommendations made by the insurance company relating to the welfare, health, and safety of employees; and
- To take no action in any form to evade the application of an experience rating modification determined in accordance with the applicable experience rating rules, as determined by NCCI, Inc.; and
- To comply with all WCIP rules and procedures and policy terms and conditions, including without limitation, those relating to audits, inspections, loss prevention, and/or premium payments, to maintain WCIP eligibility and coverage.

AGENCY CUSTOMER ID: _____

APPLICANT'S STATEMENT (Continued)**OUTSTANDING BONA FIDE DISPUTE**

The undersigned Applicant also certifies that he/she has no outstanding bona fide dispute as provided in NCCI's WCIP with any producer or company in regard to: (a) payroll records; (b) the amount of premium charged; (c) the payment of premium; (d) the carrying out of any recommendation made for the purpose of safeguarding employees; (e) the handling of any claim or accident report except the following:

LOSS SENSITIVE RATING PLAN (LSRP)

In applicable jurisdictions where the NCCI's Loss Sensitive Rating Plan (LSRP) has been approved for use, the undersigned applicant further understands and agrees that by signing below, I (applicant) acknowledge that the Loss Sensitive Rating Plan (LSRP) has been explained to me, and I agree to be bound by the terms of such plan if my standard premium meets or exceeds the premium eligibility requirement. If these conditions are met, an additional LSRP contingency deposit equal to 20% of standard premium will be required; and

- At the time of application, LSRP has been explained to applicant by the Producer submitting this application on behalf of the applicant; and
- The above referenced additional LSRP contingency deposit is in addition to the initial or deposit premium required in accordance with the WCIP.

RESIDUAL MARKET EXPIRATION LIST (APPLICABLE IN TENNESSEE ONLY)

As provided in T.C.A. 56-5-314(7), a list of employers insured under the Tennessee assigned risk plan is maintained by the Plan Administrator, and made available to interested persons upon request. As part of the application for insurance coverage, the Applicant/employer shall elect whether to be excluded from this list.

THE APPLICANT/INSURED ELECTS TO BE EXCLUDED FROM THE LIST OF EMPLOYERS IN THE TENNESSEE ASSIGNED RISK PLAN: ☐ YES ☐ NO

IMPORTANT NOTE: If on this application the Applicant/employer does not elect to be excluded from the referenced list and the related section for a "Yes" or "No" response is left blank on this application, the Applicant/employer will be deemed to be included in the list of employers insured under the Tennessee assigned risk plan.

APPLICANT COMMUNICATIONS

- By selecting the "Yes" option adjacent to this #1 section, the undersigned Applicant consents and agrees to receive electronically transmitted information and/or communications issued by NCCI by means of electronic mail (email) messages that may contain electronic documents, including without limitation, any binder/verification pages issued by NCCI, and any notifications or other communications as determined by NCCI, to the email address provided by Applicant, or provided by the Producer on Applicant's behalf, to NCCI. ☐ YES ☒ NO
- If "Yes" to #1 above, provide the valid email address to which the information, notifications and/or communications issued by NCCI should be electronically sent: _____
- By selecting the 'Yes' option adjacent to this #3 section, the undersigned Applicant consents and agrees to receive electronically transmitted policy notifications and/or communications issued by the assigned carrier by means of electronic mail (email) messages that may contain electronic documents, including without limitation, any policy documents, cancellations, endorsements, renewal and/or nonrenewal notices, and any other policy notifications and/or communications as determined by the assigned carrier, but only to the extent that the assigned carrier is able and chooses in its discretion to transmit such policy notifications and/or communications electronically to the Applicant. If the assigned carrier is unable or does not choose to transmit such policy notifications and/or communications electronically, then hard copy policy notifications and/or communications will be provided to the Applicant by the assigned carrier as determined by the assigned carrier, subject to any requirements applicable to the assigned carrier under any applicable laws or regulations. Regardless of the undersigned Applicant's selection under this #3 section to receive electronically transmitted policy notifications and/or communications from the assigned carrier, the assigned carrier must comply with any applicable laws or regulations that require a specific method of delivery for policy notifications, documents, or other information, including without limitation, mailing notices of cancellation and/or nonrenewal of policies by certified mail or certificate of mailing. ☐ YES ☒ NO
- If "Yes" to #3 above, provide the valid email address to which policy notifications and/or communications issued by the assigned carrier should be electronically sent: _____

The undersigned Applicant understands and agrees that by selecting the 'Yes' option for #1 and/or #3 above, NCCI and the assigned carrier are authorized, but neither NCCI nor the assigned carrier separately is required or obligated, to electronically transmit any notifications and/or communications referenced in #1 and/or #3 above to the designated email address provided by or on behalf of the Applicant in #2 and/or #4 above, as applicable. By consenting and agreeing to receive such electronically transmitted notifications and/or communications from NCCI and/or the assigned carrier, the undersigned Applicant releases, indemnifies, and holds harmless NCCI and the assigned carrier from any and all claims pertaining to electronically transmitted notifications and/or communications utilizing the Applicant's designated email address as provided to NCCI and/or the assigned carrier by or on behalf of the Applicant in #2 and/or #4 above, as applicable, and including, without limitation, any changes and/or updates to the undersigned Applicant's email address.

The undersigned Applicant further understands and agrees that he/she shall notify NCCI and the assigned carrier of any and all changes and/or updates to Applicant's email, mailing, and/or physical addresses, immediately upon making, implementing, or having knowledge of any such changes and/or updates.

NON-COMPLIANCE WITH AGREEMENTS OR CERTIFICATIONS

The undersigned Applicant further understands and agrees that violation of or non-compliance with any of the above agreements or certifications may result in cancellation of a policy of insurance issued under a Workers Compensation Insurance Plan and/or ineligibility for coverage under a Workers Compensation Insurance Plan.

APPLICANT'S NAME (PRINT OR TYPE) PRIME PAINTERS LLC

SIGNATURE (MUST BE OFFICER, OWNER OR PARTNER)

DATE (MM/DD/YYYY)

6-15/17

REMEMBER: BOTH THE ACORD 130 AND 133 APPLICATIONS MUST BE SIGNED BY THE APPLICANT AND DESIGNATED PRODUCER

AGENCY CUSTOMER ID: _____

PRODUCER COMMUNICATIONS

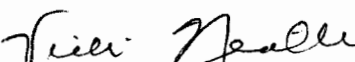
1. By selecting the "Yes" option adjacent to this #1 section, the undersigned Producer consents and agrees to receive electronically transmitted information and/or communications issued by NCCI by means of electronic mail (email) messages that may contain electronic documents, including without limitation, any binder/verification pages issued by NCCI, and any notifications or other communications as determined by NCCI, to the email address provided by the Producer to NCCI. ☐ Yes ☒ NO
2. If "Yes" to #1 above, provide the valid email address to which the information, notifications and/or communications issued by NCCI should be electronically sent:
3. By selecting the "Yes" option adjacent to this #3 section, the undersigned Producer consents and agrees to receive electronically transmitted policy notifications and/or communications issued by the assigned carrier by means of electronic mail (email) messages that may contain electronic documents, including without limitation, any policy documents, cancellations, endorsements, renewal and/or nonrenewal notices, and any other policy notifications and/or communications as determined by the assigned carrier, but only to the extent that the assigned carrier is able and chooses in its discretion to transmit such policy notifications and/or communications electronically. If the assigned carrier is unable or does not choose to transmit such policy notifications and/or communications electronically, then hard copy policy notifications and/or communications will be provided to the Producer by the assigned carrier as determined by the assigned carrier, subject to any requirements applicable to the assigned carrier under any applicable laws or regulations. Regardless of the undersigned Producer's selection under this #3 section to receive electronically transmitted policy notifications and/or communications from the assigned carrier, the assigned carrier must comply with any applicable laws or regulations that require a specific method of delivery for policy notifications, documents, or other information, including without limitation, mailing notices of cancellation and/or nonrenewal of policies by certified mail or certificate of mailing. ☐ Yes ☒ NO
4. If "Yes" to #3 above, provide the valid email address to which policy notifications and/or communications issued by the assigned carrier should be electronically sent:

The undersigned Producer understands and agrees that by selecting the "Yes" option for #1 and/or #3 above, NCCI and the assigned carrier are authorized, but neither NCCI nor the assigned carrier separately is required or obligated, to electronically transmit any notifications and/or communications referenced in #1 and/or #3 above to the designated email address provided by the Producer in #2 and/or #4 above, as applicable. By consenting and agreeing to receive such electronically transmitted notifications and/or communications from NCCI and/or the assigned carrier, the undersigned Producer releases, indemnifies, and holds harmless NCCI and the assigned carrier from any and all claims pertaining to electronically transmitted notifications and/or communications utilizing the Producer's designated email address as provided to NCCI and/or the assigned carrier by the Producer in #2 and/or #4 above, as applicable, and including, without limitation, any changes and/or updates to the undersigned Producer's email address.

The undersigned Producer further understands and agrees that he/she shall notify NCCI and the assigned carrier of any and all changes and/or updates to Producer's email, mailing, and/or physical addresses, immediately upon making, implementing, or having knowledge of any such changes and/or updates.

PRODUCER'S CERTIFICATION

THE PRODUCER ALSO CERTIFIES THAT HE/SHE HAS BEEN AUTHORIZED TO SUBMIT THE APPLICATION ON BEHALF OF THE APPLICANT AND THAT ALL INFORMATION PROVIDED ON THE ACORD 130 AND 133 IS TRUE AND ACCURATE TO THE BEST OF HIS/HER KNOWLEDGE AND BELIEF.

AGENCY FEIN 58-1294268	AGENCY LICENSE NUMBER 096142	AGENCY PHONE NUMBER (A/C, No, Ext) (770) 717-7380	AGENCY FAX NUMBER (A/C, No) (770) 717-7482
PRODUCER RESIDENT LICENSE NUMBER 497524	STATE GA	EXPIRATION DATE 07/30/2018	PRODUCER NON-RESIDENT LICENSE NUMBER
PRODUCER NAME (PRINT OR TYPE) VICKI NEVILLE	PRODUCER SIGNATURE 		DATE (MM/DD/YYYY) 6-15-17
E-MAIL ADDRESS: VICKI@FOSTERWITMER.COM			

REMEMBER: BOTH THE ACORD 130 AND 133 APPLICATIONS MUST BE SIGNED BY THE APPLICANT AND DESIGNATED PRODUCER

REMARKS (Attach additional sheets if more space is required)

NCCI APP# 42231500

WC-10 NOTICE OF ELECTION OR REJECTION OF WORKERS' COMPENSATION COVERAGE
GEORGIA STATE BOARD OF WORKERS' COMPENSATION
 NOTICE OF ELECTION OR REJECTION
 OF WORKERS' COMPENSATION COVERAGE

The use of this form is required under the provisions of: (A) O.C.G.A. §34-9-2.1 of the Workers' Compensation Law if a corporate officer or limited liability company member elects to reject coverage; (B) O.C.G.A. §34-9-2.2 if a sole proprietor or partner elects to be included as an employee; or (C) O.C.G.A. §34-9-2.3 if a farm labor employer elects to provide coverage for farm laborers. The election of corporate officers or LLC members to reject coverage shall not affect a corporate officer or LLC member being included in the count of the requisite number of employees. Any employer subject to this chapter pursuant to code Section §34-9-2(a) before the filing of any exemptions shall remain subject to this chapter without regard to the number of exemptions. THIS FORM IS NOT A WAIVER OF COVERAGE AND SHOULD NOT BE ACCEPTED AS A WAIVER OF COVERAGE.

A. CORPORATION / LIMITED LIABILITY COMPANY

I, EMIL SUIUGAN, certify that I am a member of Prime Painters LLC
(Type or Print Name) (Employer)
member 1760 Shady Creek Ln
(Office Held) (Street Address)
Lawrenceville GA 30043
(City / State / Zip Code)
☒ I elect to reject the provisions of the Georgia Workers' Compensation Law.
☐ I elect to revoke the previous rejection of _____
(Date)
 (NOTE: A maximum of five (5) officers / members may be exempted.)

B. SOLE PROPRIETOR OR PARTNER

I, _____, certify that I am a ☐ Sole Proprietor of _____
(Business Name)
☐ Partner
☐ I elect to be covered under the provisions of the Georgia Workers' Compensation Law.
☐ I elect to revoke the previous election of _____
(Date)

C. FARM LABOR

I, _____, certify that as the employer or representative of _____, that
(Business Name)
☐ I elect to provide Workers' Compensation coverage for farm laborers.
☐ I elect to revoke the previous election of _____
(Date)

D. CERTIFICATION

☒ I hereby certify that the information listed is true and correct, this the 15 day of June, 2017.
 Print Name Emil Suiugan Business Phone Number and Ext 770-827-1115 Signature [Signature]
 Business Address 1760 Shady Creek Ln Lawrenceville GA 30043

A COPY OF THIS FORM MUST BE FILED WITH YOUR CURRENT WORKERS' COMPENSATION CARRIER. IF YOU DO NOT HAVE A CARRIER, AND THE BUSINESS HAS 3 TO 5 CORPORATE OFFICERS OR LIMITED LIABILITY MEMBERS AND NO EMPLOYEES, THIS FORM MUST BE FILED WITH THE STATE BOARD OF WORKERS' COMPENSATION AT 270 PEACHTREE STREET, N.W., ATLANTA, GEORGIA 30303-1299. NOTE: DO NOT SEND TO THE BOARD IF THERE IS INSURANCE COVERAGE.

Sent: 6/9/2017 7:58:05 AM
From: NCCI_RMAPS_ADMINISTRATOR@ncci.com
To: VICKI@FOSTERWITMER.COM,VICKI@FOSTERWITMER.COM
Cc:
Subject: RMAPS Application ID 42231500 - PRIME PAINTERS LLC

From NCCI Assigned Risk Department

Applicant Name: PRIME PAINTERS LLC
Application ID: 42231500

Our records indicate payment has not yet been applied to the application ID listed above. The requested effective date has not been secured and will no longer be honored when the application becomes inactive in 48 hours. Please submit payment prior to the expiration date indicated on your work list in order to secure the requested effective date. Your prompt attention to this matter will ensure timely processing of your application.

- To access the application please go to www.ncci.com
- Select **RMAPS® Online Application Service**
- From the Work List screen, select the application number listed above.
- The application will open to the Payment screen, where you will be able to apply the payment by credit card or EFT.

Once payment has been applied, your application will be assigned to an Assigned Risk Analyst and the effective date will be secured if all pertinent information is received.

Thank you.

Sent: 6/12/2017 6:15:40 AM
From: NCCI_RMAPS_ADMINISTRATOR@ncci.com
To: VICKI@FOSTERWITMER.COM,VICKI@FOSTERWITMER.COM
Cc:
Subject: RMAPS Application ID 42231500 - PRIME PAINTERS LLC

From NCCI Assigned Risk Department

Applicant Name: PRIME PAINTERS LLC
Application ID: 42231500

Our records indicate payment was not applied to the application ID listed above, the application has now been placed in an inactive status and the effective date will no longer be honored. The application will be available from the inactive application section on your work list. In order to reactivate the application please follow the steps below

Please note: An application may only be reactivated once.

- To access the application please go to www.ncci.com
- Select **RMAPS® Online Application Service**
- From the Work List screen select the application number listed above from the inactive section.
- Enter a new effective date (the earliest effective date available is tomorrow).
- Select the "Next Steps" button.
- On the Payment screen, you will be able to apply the payment by credit card or EFT.

Once payment has been applied, your application will be assigned to an Assigned Risk Analyst and the effective date will be secured if all pertinent information is received.

Thank you.

Sent: 6/14/2017 4:34:38 PM

From: RMAPS_Finance_Admin@ncci.com

To: VICKI@FOSTERWITMER.COM,VICKI@FOSTERWITMER.COM

Cc:

Subject: RMAPS Application # 42231500 - Payment Confirmation (THIS EMAIL WILL NOT ACCEPT A RESPONSE)

This is to confirm that NCCI, Inc. has received a premium deposit payment request for the above referenced application submitted through **RMAPS® Online Application Service**, as follows:

Confirmation: Electronic Payment (ACH)

Producer:	VICKI NEVILLE	Payment Date:	06/14/2017
Agency:	FOSTER AND ASSOCIATES DBA FOSTER WITMER INS AGENCY	Account Holder Name:	FOSTER WITMER
Risk Name:	PRIME PAINTERS LLC	Bank Routing Number:	061107816
Application ID:	42231500	Financial Institution:	FIRST CITIZENS BANK DIV OF FIRSTCITIZENS BANK TRUST CO
Payment Amount:	\$1620	Bank Account Number:	xxxxxxxx5401

Thank you for your ACH payment request.

Premium deposit payments are not considered paid until NCCI has received the funds from your financial institution.

Please forward this information to the applicant if payment was made from their account.

Thank you for using **RMAPS® Online Application Service**.

This automated email will not accept a response. If you have any questions, please e-mail Customer Service, or call NCCI Assigned Risk toll free 800-NCCI-123 (800-622-4123).

Sent: 6/19/2017 12:46:54 PM
From: NCCI_Reply_Required@ncci.com
To: VICKI@FOSTERWITMER.COM,VICKI@FOSTERWITMER.COM
Cc:
Subject: First Notice - RMAPS Application ID 42231500 - PRIME PAINTERS LLC

FIRST NOTICE

Thank you for submitting the above referenced application for workers compensation insurance. Additional information is required in order to determine the applicant's eligibility for coverage under The Plan.

The established effective date may be honored provided the requested information is received at the National Council on Compensation Insurance (NCCI) service center by **06/21/2017 8:00 P.M. EST**, and the application is otherwise deemed eligible for coverage.

For prompt and efficient processing of your application, please choose one of the following options:

- Please select "reply all" to this email and provide the answers to the requested information. Do not change any information in the subject line, as the subject line is used to associate your email to the application.

OR

- Log into NCCI.com and go to the RMAPS® Online Application Service, click on the application ID number and provide answers in the text boxes available.

REQUESTED INFORMATION

Please provide all pages of the signed ACORD® 130 and ACORD® 133 applications. On the ACORD® 130, the applicant must initial the privacy statement (if applicable) and both the producer and applicant must sign under the privacy statement. On the ACORD® 133, the producer must sign page 4 and the applicant must sign and clearly print their name. Please attach all pages of the signed ACORD® 130 and 133 applications to this email, upload directly in the RMAPS® system or fax to the Assigned Risk Analyst.

1. If you are receiving this notice then the ACORD forms have not been received. Both ACORD forms are required to continue processing this application. The ACORD 130 and 133 require signatures of BOTH the producer and the applicant. Please fax/upload the signed copies (ALL 8 pages) of the ACORD 130 & 133 forms with BOTH producer and applicant signatures on each application.

The established effective date will be rendered void and coverage will not be afforded unless the requested information is received by the date and time referenced above.

If you have any questions regarding the contents of this letter please contact the Assigned Risk Analyst named below.

Sincerely,

TANYA THREATS
Assigned Risk Analyst

Phone: (800) 622-4123 Ext. 1136

Sent: 6/22/2017 11:35:13 AM
From: NCCI_Reply_Required@ncci.com
To: VICKI@FOSTERWITMER.COM,VICKI@FOSTERWITMER.COM
Cc:
Subject: Second Notice - RMAPS Application ID 42231500 - PRIME PAINTERS LLC

SECOND NOTICE

Thank you for submitting the above referenced application for workers compensation insurance. Additional information is required in order to determine the applicant's eligibility for coverage under The Plan.

The established effective date may be honored provided the requested information is received at the National Council on Compensation Insurance (NCCI) service center by **06/26/2017 8:00 P.M. EST**, and the application is otherwise deemed eligible for coverage.

For prompt and efficient processing of your application, please choose one of the following options:

- Please select "reply all" to this email and provide the answers to the requested information. Do not change any information in the subject line, as the subject line is used to associate your email to the application.

OR

- Log into NCCI.com and go to the RMAPS® Online Application Service, click on the application ID number and provide answers in the text boxes available.

REQUESTED INFORMATION

The established effective date will be rendered void and coverage will not be afforded unless the requested information is received by the date and time referenced above.

If you have any questions regarding the contents of this letter please contact the Assigned Risk Analyst named below.

Sincerely,

TANYA THREATS
Assigned Risk Analyst
Phone: (800) 622-4123 Ext. 1136

Sent: 6/26/2017 10:07:08 AM
From: NCCI_Reply_Required@ncci.com
To: VICKI@FOSTERWITMER.COM,VICKI@FOSTERWITMER.COM
Cc:
Subject: Final Notice - RMAPS Application ID 42231500 - PRIME PAINTERS LLC

FINAL NOTICE

Thank you for submitting the above referenced application for workers compensation insurance. Additional information is required in order to determine the applicant's eligibility for coverage under The Plan.

The established effective date may be honored provided the requested information is received at the National Council on Compensation Insurance (NCCI) service center by **06/28/2017 8:00 P.M. EST**, and the application is otherwise deemed eligible for coverage.

For prompt and efficient processing of your application, please choose one of the following options:

- Please select "reply all" to this email and provide the answers to the requested information. Do not change any information in the subject line, as the subject line is used to associate your email to the application.

OR

- Log into NCCI.com and go to the RMAPS® Online Application Service, click on the application ID number and provide answers in the text boxes available.

REQUESTED INFORMATION

As per my voicemail:

1. If you are receiving this notice then the ACORD forms have not been received. Both ACORD forms are required to continue processing this application. The ACORD 130 and 133 require signatures of BOTH the producer and the applicant. Please fax/upload the signed copies (ALL 8 pages) of the ACORD 130 & 133 forms with BOTH producer and applicant signatures on each application.

**** Signature pages were cut off in the submission ****

The established effective date will be rendered void and coverage will not be afforded unless the requested information is received by the date and time referenced above.

If you have any questions regarding the contents of this letter please contact the Assigned Risk Analyst named below.

Sincerely,

TANYA THREATS
Assigned Risk Analyst
Phone: (800) 622-4123 Ext. 1136

GENERAL INFORMATION (continued)**EXPLAIN ALL "YES" RESPONSES**

	Y/N
17. ANY OTHER INSURANCE WITH THIS INSURER?	N
18. ANY PRIOR COVERAGE DECLINED / CANCELLED / NON-RENEWED IN THE LAST THREE (3) YEARS? (Missouri Applicants - Do not answer this question) CURRENT CARRIER NON RENEWED NO LONGER WRITING IN GEORGIA	Y
19. ARE EMPLOYEE HEALTH PLANS PROVIDED?	N
20. DO ANY EMPLOYEES PERFORM WORK FOR OTHER BUSINESSES OR SUBSIDIARIES?	N
21. DO YOU LEASE EMPLOYEES TO OR FROM OTHER EMPLOYERS?	N
22. DO ANY EMPLOYEES PREDOMINANTLY WORK AT HOME? If "YES", # of Employees: _____	N
23. ANY TAX LIENS OR BANKRUPTCY WITHIN THE LAST FIVE (5) YEARS? (If "YES", please specify)	N
24. ANY UNDISPUTED AND UNPAID WORKERS COMPENSATION PREMIUM DUE FROM YOU OR ANY COMMONLY MANAGED OR OWNED ENTERPRISES? (If "YES", explain including entity name(s) and policy number(s))	N

SIGNATURE

Copy of the Notice of Information Practices (Privacy) has been given to the applicant. (Not required in all states, contact your agent or broker for your state's requirements.)

PERSONAL INFORMATION ABOUT YOU, INCLUDING INFORMATION FROM A CREDIT OR OTHER INVESTIGATIVE REPORT, MAY BE COLLECTED FROM PERSONS OTHER THAN YOU IN CONNECTION WITH THIS APPLICATION FOR INSURANCE AND SUBSEQUENT AMENDMENTS AND RENEWALS. SUCH INFORMATION AS WELL AS OTHER PERSONAL AND PRIVILEGED INFORMATION COLLECTED BY US OR OUR AGENTS MAY IN CERTAIN CIRCUMSTANCES BE DISCLOSED TO THIRD PARTIES WITHOUT YOUR AUTHORIZATION. CREDIT SCORING INFORMATION MAY BE USED TO HELP DETERMINE EITHER YOUR ELIGIBILITY FOR INSURANCE OR THE PREMIUM YOU WILL BE CHARGED. WE MAY USE A THIRD PARTY IN CONNECTION WITH THE DEVELOPMENT OF YOUR SCORE. YOU MAY HAVE THE RIGHT TO REVIEW YOUR PERSONAL INFORMATION IN OUR FILES AND REQUEST CORRECTION OF ANY INACCURACIES. YOU MAY ALSO HAVE THE RIGHT TO REQUEST IN WRITING THAT WE CONSIDER EXTRAORDINARY LIFE CIRCUMSTANCES IN CONNECTION WITH THE DEVELOPMENT OF YOUR CREDIT SCORE. THESE RIGHTS MAY BE LIMITED IN SOME STATES. PLEASE CONTACT YOUR AGENT OR BROKER TO LEARN HOW THESE RIGHTS MAY APPLY IN YOUR STATE OR FOR INSTRUCTIONS ON HOW TO SUBMIT A REQUEST TO US FOR A MORE DETAILED DESCRIPTION OF YOUR RIGHTS AND OUR PRACTICES REGARDING PERSONAL INFORMATION. (Not applicable in AZ, CA, DE, KS, MA, MN, ND, NY, OR, VA, or WV. Specific ACORD 38s are available for applicants in these states.) (Applicant's Initials) DES

Applicable in AL, AR, DC, LA, MD, NM, RI and WV: Any person who knowingly (or willfully)* presents a false or fraudulent claim for payment of a loss or benefit or knowingly (or willfully)* presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. *Applies in MD Only.

Applicable in CO: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

Applicable in FL and OK: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony (of the third degree)*. *Applies in FL Only.

Applicable in KS: Any person who, knowingly and with intent to defraud, presents, causes to be presented or prepares with knowledge or belief that it will be presented to or by an insurer, purported insurer, broker or any agent thereof, any written statement as part of, or in support of, an application for the issuance of, or the rating of an insurance policy for personal or commercial insurance, or a claim for payment or other benefit pursuant to an insurance policy for commercial or personal insurance which such person knows to contain materially false information concerning any fact material thereto; or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act.

Applicable in KY, NY, OH and PA: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties (not to exceed five thousand dollars and the stated value of the claim for each such violation)*. *Applies in NY Only.

Applicable in ME, TN, VA and WA: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties (may)* include imprisonment, fines and denial of insurance benefits. *Applies in ME Only.

Applicable in NJ: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

Applicable in OR: Any person who knowingly and with intent to defraud or solicit another to defraud the insurer by submitting an application containing a false statement as to any material fact may be violating state law.

Applicable in PR: Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation by a fine of not less than five thousand dollars (\$5,000) and not more than ten thousand dollars (\$10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances [be] present, the penalty thus established may be increased to a maximum of five (5) years. If extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

Applicable in UT: Any person who knowingly presents false or fraudulent underwriting information, files or causes to be filed a false or fraudulent claim for disability compensation or medical benefits, or submits a false or fraudulent report or billing for health care fees or other professional services is guilty of a crime and may be subject to fines and confinement in state prison.

THE UNDERSIGNED IS AN AUTHORIZED REPRESENTATIVE OF THE APPLICANT AND REPRESENTS THAT REASONABLE INQUIRY HAS BEEN MADE TO OBTAIN THE ANSWERS TO QUESTIONS ON THIS APPLICATION. HE/SHE REPRESENTS THAT THE ANSWERS ARE TRUE, CORRECT AND COMPLETE TO THE BEST OF HIS/HER KNOWLEDGE.

APPLICANT'S SIGNATURE (Must be Officer, Owner or Partner) _____ DATE _____ PRODUCER'S SIGNATURE _____ NATIONAL PRODUCER NUMBER _____

APPLICANT'S STATEMENT (Continued)**OUTSTANDING BONA FIDE DISPUTE**

The undersigned Applicant also certifies that he/she has no outstanding bona fide dispute as provided in NCCI's WCIP with any producer or company in regard to: (a) payroll records; (b) the amount of premium charged; (c) the payment of premium; (d) the carrying out of any recommendation made for the purpose of safeguarding employees; (e) the handling of any claim or accident report except the following:

LOSS SENSITIVE RATING PLAN (LSRP)

In applicable jurisdictions where the NCCI's Loss Sensitive Rating Plan (LSRP) has been approved for use, the undersigned applicant further understands and agrees that by signing below, I (applicant) acknowledge that the Loss Sensitive Rating Plan (LSRP) has been explained to me, and I agree to be bound by the terms of such plan if my standard premium meets or exceeds the premium eligibility requirement. If these conditions are met, an additional LSRP contingency deposit equal to 20% of standard premium will be required; and

- At the time of application, LSRP has been explained to applicant by the Producer submitting this application on behalf of the applicant; and
- The above referenced additional LSRP contingency deposit is in addition to the initial or deposit premium required in accordance with the WCIP.

RESIDUAL MARKET EXPIRATION LIST (APPLICABLE IN TENNESSEE ONLY)

As provided in T.C.A. 56-5-314(7), a list of employers insured under the Tennessee assigned risk plan is maintained by the Plan Administrator, and made available to interested persons upon request. As part of the application for insurance coverage, the Applicant/employer shall elect whether to be excluded from this list:

THE APPLICANT/INSURED ELECTS TO BE EXCLUDED FROM THE LIST OF EMPLOYERS IN THE TENNESSEE ASSIGNED RISK PLAN: ☐ YES ☐ NO

IMPORTANT NOTE: If on this application the Applicant/employer does not elect to be excluded from the referenced list and the related section for a "Yes" or "No" response is left blank on this application, the Applicant/employer will be deemed to be included in the list of employers insured under the Tennessee assigned risk plan.

APPLICANT COMMUNICATIONS

- By selecting the "Yes" option adjacent to this #1 section, the undersigned Applicant consents and agrees to receive electronically transmitted information and/or communications issued by NCCI by means of electronic mail (email) messages that may contain electronic documents, including without limitation, any binder/verification pages issued by NCCI, and any notifications or other communications as determined by NCCI, to the email address provided by Applicant, or provided by the Producer on Applicant's behalf, to NCCI. ☐ YES ☒ NO
- If "Yes" to #1 above, provide the valid email address to which the information, notifications and/or communications issued by NCCI should be electronically sent:
- By selecting the "Yes" option adjacent to this #3 section, the undersigned Applicant consents and agrees to receive electronically transmitted policy notifications and/or communications issued by the assigned carrier by means of electronic mail (email) messages that may contain electronic documents, including without limitation, any policy documents, cancellations, endorsements, renewal and/or nonrenewal notices, and any other policy notifications and/or communications as determined by the assigned carrier, but only to the extent that the assigned carrier is able and chooses in its discretion to transmit such policy notifications and/or communications electronically to the Applicant. If the assigned carrier is unable or does not choose to transmit such policy notifications and/or communications electronically, then hard copy policy notifications and/or communications will be provided to the Applicant by the assigned carrier as determined by the assigned carrier, subject to any requirements applicable to the assigned carrier under any applicable laws or regulations. Regardless of the undersigned Applicant's selection under this #3 section to receive electronically transmitted policy notifications and/or communications from the assigned carrier, the assigned carrier must comply with any applicable laws or regulations that require a specific method of delivery for policy notifications, documents, or other information, including without limitation, mailing notices of cancellation and/or nonrenewal of policies by certified mail or certificate of mailing. ☐ YES ☒ NO
- If "Yes" to #3 above, provide the valid email address to which policy notifications and/or communications issued by the assigned carrier should be electronically sent:

The undersigned Applicant understands and agrees that by selecting the "Yes" option for #1 and/or #3 above, NCCI and the assigned carrier are authorized, but neither NCCI nor the assigned carrier separately is required or obligated, to electronically transmit any notifications and/or communications referenced in #1 and/or #3 above to the designated email address provided by or on behalf of the Applicant in #2 and/or #4 above, as applicable. By consenting and agreeing to receive such electronically transmitted notifications and/or communications from NCCI and/or the assigned carrier, the undersigned Applicant releases, indemnifies, and holds harmless NCCI and the assigned carrier from any and all claims pertaining to electronically transmitted notifications and/or communications utilizing the Applicant's designated email address as provided to NCCI and/or the assigned carrier by or on behalf of the Applicant in #2 and/or #4 above, as applicable, and including, without limitation, any changes and/or updates to the undersigned Applicant's email address.

The undersigned Applicant further understands and agrees that he/she shall notify NCCI and the assigned carrier of any and all changes and/or updates to Applicant's email, mailing, and/or physical addresses, immediately upon making, implementing, or having knowledge of any such changes and/or updates.

NON-COMPLIANCE WITH AGREEMENTS OR CERTIFICATIONS

The undersigned Applicant further understands and agrees that violation of or non-compliance with any of the above agreements or certifications may result in cancellation of a policy of insurance issued under a Workers Compensation Insurance Plan and/or ineligibility for coverage under a Workers Compensation Insurance Plan.

APPLICANT'S NAME (PRINT OR TYPE) PRIME PAINTERS LLC

SIGNATURE (MUST BE OFFICER, OWNER OR PARTNER)

DATE (MM/DD/YYYY)



WORKERS COMPENSATION APPLICATION

DATE (MM/DD/YYYY)

06/14/2017

AGENCY NAME AND ADDRESS FOSTER AND ASSOCIATES DBA FOSTER WITMER INS AGENCY 3100 BRECKINRIDGE BLVD STE 510 DULUTH, GA 30096-7507		COMPANY: UNDERWRITER: APPLICANT NAME: PRIME PAINTERS LLC OFFICE PHONE: (770) 827-1115 MOBILE PHONE: MAILING ADDRESS (Including Zip + 4) 1760 SHADY CREEK LN LAWRENCEVILLE, GA 30043-2709	
PRODUCER NAME: VICKI NEVILLE CS REPRESENTATIVE VICKI NEVILLE NAME: OFFICE PHONE (770) 717-7380 (A/C, No, Ext): MOBILE PHONE: FAX (A/C, NO): (770) 717-7482 EMAIL ADDRESS: VICKI@FOSTERWITMER.COM CODE: SUB CODE:		YRS IN BUS: 10 SIC: NAICS: Website Address: E-MAIL ADDRESS: SOLE PROPRIETOR CORPORATION X LLC TRUST UNINCORPORATED ASSOCIATION PARTNERSHIP SUBCHAPTER "S" CORP JOINT VENTURE OTHER CREDIT BUREAU NAME: FEDERAL EMPLOYER ID NUMBER NCCI RISK ID NUMBER: ID NUMBER: OTHER RATING BUREAU ID EMPLOYER REGISTRATION NUMBER OR STATE	
AGENCY CUSTOMER ID:		723	

STATUS OF SUBMISSION

BILLING / AUDIT INFORMATION

<input type="checkbox"/> QUOTE <input type="checkbox"/> BOUND (Give date and/or attach copy) <input checked="" type="checkbox"/> ASSIGNED RISK (Attach ACORD 133)	<input type="checkbox"/> ISSUE POLICY <input type="checkbox"/> BILLING PLAN <input type="checkbox"/> AGENCY BILL <input type="checkbox"/> DIRECT BILL	<input type="checkbox"/> PAYMENT PLAN <input type="checkbox"/> ANNUAL <input type="checkbox"/> SEMI-ANNUAL <input type="checkbox"/> QUARTERLY	<input type="checkbox"/> OTHER: % DOWN: <input type="checkbox"/> AT EXPIRATION <input type="checkbox"/> SEMI-ANNUAL <input type="checkbox"/> QUARTERLY	<input type="checkbox"/> MONTHLY
---	--	--	---	----------------------------------

LOCATIONS

LOC #	Highest Floor	STREET, CITY, COUNTY, STATE, ZIP CODE
1		1760 SHADY CREEK LN LAWRENCEVILLE, GA 30043-2709

POLICY INFORMATION

PROPOSED EFF DATE 6/15/2017		PROPOSED EXP DATE 6/15/2018		NORMAL ANNIVERSARY RATING DATE		PARTICIPATING NON-PARTICIPATING		RETRO PLAN	
PART 1 - WORKERS COMPENSATION (States) GA		PART 2 - EMPLOYER'S LIABILITY \$ 1,000,000 EACH ACCIDENT \$ 1,000,000 DISEASE-POLICY LIMIT \$ 1,000,000 DISEASE-EACH EMPLOYEE		PART 3 - OTHER STATES INS		DEDUCTIBLES (N / A in WI) MEDICAL INDEMNITY		AMOUNT / % (N / A in WI) OTHER COVERAGES U.S.L. & H. VOLUNTARY COMP FOREIGN COV MANAGED CARE	
DIVIDEND PLAN/SAFETY GROUP		ADDITIONAL COMPANY INFORMATION							
SPECIFY ADDITIONAL COVERAGES / ENDORSEMENTS (Attach ACORD 101, Additional Remarks Schedule, if more space is required)									

TOTAL ESTIMATED ANNUAL PREMIUM - ALL STATES

TOTAL ESTIMATED ANNUAL PREMIUM ALL STATES \$1,620.00	TOTAL MINIMUM PREMIUM ALL STATES \$0.00	TOTAL DEPOSIT PREMIUM ALL STATES \$1,620.00
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CONTACT INFORMATION

TYPE	NAME	OFFICE PHONE	MOBILE PHONE	E-MAIL
INSPECTION	EMIL SUIUGAN	(770) 827-1115		
ACTING RECORD	EMIL SUIUGAN	(770) 827-1115		
CLAIMS INFO	EMIL SUIUGAN	(770) 827-1115		

INDIVIDUALS INCLUDED / EXCLUDED

PARTNERS, OFFICERS, RELATIVES (Must be employed by business operations) TO BE INCLUDED OR EXCLUDED (Remuneration/Payroll to be included must be part of rating information section.)
 Exclusions in Missouri must meet the requirements of Section 287.090 RSMo.

STATE	LOC #	NAME	DATE OF BIRTH	TITLE/ RELATIONSHIP	OWNER-SHIP %	DUTIES	INC/EXC	CLASS CODE	REMUNERATION/ PAYROLL
GA		SUIUGAN, EMIL		MEMBER	100	OWNER/OPERATOR	E	5474	56300

AGENCY CUSTOMER ID: _____

STATE RATING SHEET # 1 OF 1 SHEETS

STATE RATING WORKSHEET

FOR MULTIPLE STATES, ATTACH AN ADDITIONAL PAGE 2 OF THIS FORM

RATING INFORMATION - STATE: Georgia[illegible]

PREMIUM

STATE:	FACTOR	FACTORED PREMIUM		FACTOR	FACTORED PREMIUM
TOTAL	N / A	\$0			\$0
INCREASED LIMITS		\$120.00	SCHEDULE RATING *		\$0
DEDUCTIBLE *	0	\$0	CCPAP		
			STANDARD PREMIUM		\$105.00
EXPERIENCE OR MERIT MODIFICATION	0	\$0	PREMIUM DISCOUNT		\$0.00
		\$0	EXPENSE CONSTANT	N / A	\$160.00
ASSIGNED RISK SURCHARGE *	0	\$0.00	TAXES / ASSESSMENTS *	N / A	\$0.00
ARAP *	0.00	\$0.00			\$0

* N / A in Wisconsin

TOTAL ESTIMATED ANNUAL PREMIUM	MINIMUM PREMIUM	DEPOSIT PREMIUM
\$1,620.00	\$1,620.00	

REMARKS (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)

NCCI APP# 42231500

AGENCY CUSTOMER ID: _____

PRIOR CARRIER INFORMATION / LOSS HISTORY

PROVIDE INFORMATION FOR THE PAST 5 YEARS AND USE THE REMARKS SECTION FOR LOSS DETAILS						LOSS RUN ATTACHED	
YEAR	CARRIER & POLICY NUMBER	ANNUAL PREMIUM	MOD	# CLAIMS	AMOUNT PAID	RESERVE	
	CO:						
	POL #:						
	CO:						
	POL #:						
	CO:						
	POL #:						
	CO:						
	POL #:						
	CO:						
	POL #:						

NATURE OF BUSINESS / DESCRIPTION OF OPERATIONS

GIVE COMMENTS AND DESCRIPTIONS OF BUSINESS, OPERATIONS AND PRODUCTS: MANUFACTURING - RAW MATERIALS, PROCESSES, PRODUCT, EQUIPMENT; CONTRACTOR - TYPE OF WORK, SUB-CONTRACTS; MERCANTILE - MERCHANDISE, CUSTOMERS, DELIVERIES; SERVICE - TYPE, LOCATION; FARM - ACREAGE, ANIMALS, MACHINERY, SUB-CONTRACTS.

PAINTING

GENERAL INFORMATION

EXPLAIN ALL "YES" RESPONSES	Y / N
1. DOES APPLICANT OWN, OPERATE OR LEASE AIRCRAFT / WATERCRAFT?	N
2. DO / HAVE PAST, PRESENT OR DISCONTINUED OPERATIONS INVOLVE(D) STORING, TREATING, DISCHARGING, APPLYING, DISPOSING, OR TRANSPORTING OF HAZARDOUS MATERIAL? (e.g. landfills, wastes, fuel tanks, etc)	N
3. ANY WORK PERFORMED UNDERGROUND OR ABOVE 15 FEET?	N
4. ANY WORK PERFORMED ON BARGES, VESSELS, DOCKS, BRIDGE OVER WATER?	N
5. IS APPLICANT ENGAGED IN ANY OTHER TYPE OF BUSINESS?	N
6. ARE SUB-CONTRACTORS USED? (If "YES", give % of work subcontracted)	N
7. ANY WORK SUBLET WITHOUT CERTIFICATES OF INSURANCE? (If "YES", payroll for this work must be included in the State Rating Worksheet on Page 2)	N
8. IS A WRITTEN SAFETY PROGRAM IN OPERATION?	N
9. ANY GROUP TRANSPORTATION PROVIDED?	N
10. ANY EMPLOYEES UNDER 16 OR OVER 60 YEARS OF AGE?	N
11. ANY SEASONAL EMPLOYEES?	N
12. IS THERE ANY VOLUNTEER OR DONATED LABOR? (If "YES", please specify)	N
13. ANY EMPLOYEES WITH PHYSICAL HANDICAPS?	N
14. DO EMPLOYEES TRAVEL OUT OF STATE? (If "YES", indicate state(s) of travel and frequency)	N
15. ARE ATHLETIC TEAMS SPONSORED?	N
16. ARE PHYSICALS REQUIRED AFTER OFFERS OF EMPLOYMENT ARE MADE?	N

AGENCY CUSTOMER ID: _____



WORKERS COMPENSATION INSURANCE PLAN ASSIGNED RISK SECTION

DATE (MM/DD/YYYY)

06/14/2017

THIS FORM ALONG WITH AN ACORD 130 WORKERS COMPENSATION APPLICATION CONSTITUTE AN APPLICATION FOR WORKERS COMPENSATION INSURANCE PLAN (ASSIGNED RISK) COVERAGE. THIS FORM MUST BE ATTACHED TO AN ACORD 130 FOR SUBMISSION. PLEASE REFER TO THE STATE SPECIFIC INSTRUCTIONS PAGE FOR SPECIFIC REQUIREMENTS.

APPLICANT NAME
PRIME PAINTERS LLC

PROPOSED EFF DATE
06/15/2017

SUPPLEMENTAL INFORMATION

PAYROLL OFFICE NAME, ADDRESS AND TELEPHONE NUMBER (A PO BOX ADDRESS ALONE IS NOT ACCEPTABLE. PLEASE PROVIDE DRIVING INSTRUCTIONS IF A ROUTE ADDRESS IS SHOWN.)

EMIL SUIUGAN
1760 SHADY CREEK LN
LAWRENCEVILLE, GA 30043-2709

STATE DEVELOPING HIGHEST PAYROLL: GA

EXPLAIN ALL "YES" RESPONSES IN THE REMARKS SECTION

	YES	NO																								
1. HAS THERE BEEN PREVIOUS WORKERS COMPENSATION COVERAGE: IN THIS STATE? IN ANY OTHER STATE? -IF NO TO BOTH QUESTIONS, WAS THIS DUE TO: <input type="checkbox"/> NEW BUSINESS <input type="checkbox"/> SELF INSURED-INDEP <input type="checkbox"/> SELF INSURED-GROUP <input type="checkbox"/> # EMPLOYEES	<input type="checkbox"/> Y <input type="checkbox"/>	<input type="checkbox"/> N <input type="checkbox"/>																								
2. IS THERE ANY UNPAID WORKERS COMPENSATION PREMIUM DUE OR IN DISPUTE FROM YOU OR ANY COMMONLY MANAGED OR OWNED ENTERPRISES? IF YES, EXPLAIN INCLUDING ENTITY NAME(S) AND POLICY NUMBER(S).	<input type="checkbox"/>	<input type="checkbox"/> N																								
3. YEAR APPLICANT'S BUSINESS BEGAN: 2007																										
4. HAS THERE BEEN A NAME CHANGE, CONSOLIDATION, MERGER ACQUISITION, SALE, PURCHASE OR TRANSFER OF ASSETS OR OWNERSHIP CHANGE DURING THE PAST FIVE (5) YEARS? IF YES, PROVIDE A COMPLETED ERM-14 FORM.	<input type="checkbox"/>	<input type="checkbox"/> N																								
5. IS APPLICANT RELATED THROUGH COMMON MANAGEMENT OR OWNERSHIP TO ANY ENTITY NOT LISTED ON THE ACORD 130 FORM, WHETHER COVERAGE IS REQUIRED OR NOT? IF YES, PROVIDE A COMPLETED ERM-14 FORM.	<input type="checkbox"/>	<input type="checkbox"/> N																								
6. DO YOU LEASE WORKERS FROM A PROFESSIONAL EMPLOYER ORGANIZATION (PEO)? IF YES, REFER TO WCIP INSTRUCTIONS. NAME OF PROFESSIONAL EMPLOYER ORGANIZATION (PEO): _____	<input type="checkbox"/>	<input type="checkbox"/> N																								
7. DO YOU LEASE WORKERS TO A CLIENT COMPANY? IF YES, REFER TO WCIP INSTRUCTIONS.	<input type="checkbox"/>	<input type="checkbox"/> N																								
8. ARE YOU SEEKING TO COVER THE LEASED WORKERS? IF YES, REFER TO WCIP INSTRUCTIONS.	<input type="checkbox"/>	<input type="checkbox"/> N																								
9. DO YOU PROVIDE TEMPORARY ARRANGEMENT SERVICES TO OTHER EMPLOYERS? IF YES, PROVIDE A TEMPORARY LABOR CONTRACTOR EMPLOYEE FORM.	<input type="checkbox"/>	<input type="checkbox"/> N																								
10. DO YOU HAVE A FRANCHISE OR LICENSING AGREEMENT? IF YES, PROVIDE A COPY OF THE AGREEMENT.	<input type="checkbox"/>	<input type="checkbox"/> N																								
11. IS COVERAGE REQUESTED FOR A SPORTS TEAM? IF YES, PROVIDE NAME OF SPORTS TEAM AND DOMICILED STATE. NAME OF SPORTS TEAM: _____ DOMICILED STATE: _____	<input type="checkbox"/>	<input type="checkbox"/> N																								
12. DO TRUCKING CLASSIFICATIONS APPLY? IF YES, COMPLETE QUESTIONS 13 - 20.	<input type="checkbox"/>	<input type="checkbox"/> N																								
13. DO YOU OR YOUR EMPLOYEES REGULARLY OPERATE FROM A BASE TERMINAL(S) WHICH IS (ARE) USED TO LOAD, UNLOAD, STORE OR TRANSFER FREIGHT? IF YES, PLEASE PROVIDE A LIST OF TERMINAL ADDRESSES:	<input type="checkbox"/>	<input type="checkbox"/>																								
<table border="1"> <thead> <tr> <th>#</th> <th>STREET</th> <th>CITY</th> <th>COUNTY</th> <th>ST</th> <th>ZIP CODE</th> </tr> </thead> <tbody> <tr> <td>1</td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>2</td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>3</td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> </tbody> </table>	#	STREET	CITY	COUNTY	ST	ZIP CODE	1						2						3							
#	STREET	CITY	COUNTY	ST	ZIP CODE																					
1																										
2																										
3																										
14. CAN EACH DRIVER'S STATE OF MAJORITY DRIVING TIME BE ESTABLISHED THROUGH VERIFIABLE RECORDS OR LOGS?	<input type="checkbox"/>	<input type="checkbox"/>																								
15. PLEASE PROVIDE A LIST OF ALL DRIVERS/HELPERS AND THEIR STATE OF RESIDENCE:																										
<table border="1"> <thead> <tr> <th></th> <th>DRIVER NAME</th> <th>TERMINAL # (SEE ABOVE)</th> <th>MAJORITY DRIVING STATE</th> <th>RESIDENCE STATE</th> </tr> </thead> <tbody> <tr> <td>1</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>2</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>3</td> <td></td> <td></td> <td></td> <td></td> </tr> </tbody> </table>		DRIVER NAME	TERMINAL # (SEE ABOVE)	MAJORITY DRIVING STATE	RESIDENCE STATE	1					2					3										
	DRIVER NAME	TERMINAL # (SEE ABOVE)	MAJORITY DRIVING STATE	RESIDENCE STATE																						
1																										
2																										
3																										
16. WHAT TYPE(S) OF GOODS ARE BEING HAULED? (e.g., coal, dry goods, explosives, scaffolding, water / waste fluids from oil field sites, etc.)																										
17. DO YOU OWN THESE GOODS?	<input type="checkbox"/>	<input type="checkbox"/>																								
18. IS APPLICANT UNDER EXCLUSIVE CONTRACT WITH ANY RETAIL STORE(S)? IF YES, PROVIDE COPY OF CONTRACT(S).	<input type="checkbox"/>	<input type="checkbox"/>																								
19. IS APPLICANT UNDER EXCLUSIVE CONTRACT WITH ANY POSTAL SERVICE? IF YES, PROVIDE COPY OF CONTRACT(S).	<input type="checkbox"/>	<input type="checkbox"/>																								
20. WITHIN WHAT MILE RADIUS IS HAULING DONE? # MILES: _____																										

AGENCY CUSTOMER ID: _____

INSURANCE COMPANIES WHO HAVE OFFERED/REFUSED INSURANCE					YES	NO
21. HAVE YOU RECEIVED ANY OFFERS OF VOLUNTARY COVERAGE? (INCLUDE MULTI-LINE OR RETROSPECTIVE RATING PLAN, IF APPLICABLE) IF YES, PROVIDE FULL DETAILS INCLUDING PLAN TERMS IN THE REMARKS SECTION.					<input type="checkbox"/>	<input checked="" type="checkbox"/>
22. INDICATE THE NUMBER OF INSURANCE COMPANIES WHICH HAVE REFUSED THE APPLICANT COVERAGE IN THE LAST 60 DAYS (OR IN ACCORDANCE WITH STATE SPECIFIC GUIDELINES): 4						
LIST COMPANY NAMES, REPRESENTATIVE NAMES, TELEPHONE NUMBERS AND DATES OF REFUSALS. REFER TO WCIP TO VERIFY REQUIREMENTS.						
COMPANY NAME	REPRESENTATIVE NAME	TELEPHONE NUMBER	DATE OF REFUSAL	COMMENTS		
PREMIUM PAYMENT (Refer to WCIP instruction sheet for state requirements)					YES	NO
23. IS THE PREMIUM FINANCED THROUGH A THIRD PARTY PREMIUM FINANCE COMPANY? IF YES, A COPY OF THE AGREEMENT MUST BE PROVIDED.					<input type="checkbox"/>	<input checked="" type="checkbox"/>
24. IN APPLICABLE JURISDICTIONS ON QUALIFYING RISKS, IS THE LOSS SENSITIVE RATING PROGRAM (LSRP) CONTINGENCY DEPOSIT BEING PAID IN FULL AT THIS TIME?					<input type="checkbox"/>	<input checked="" type="checkbox"/>
25. INITIAL OR ESTIMATED ANNUAL DEPOSIT PREMIUM IS REQUIRED IN ORDER TO BIND COVERAGE. THE FOLLOWING PAYMENT METHODS MAY BE USED TO SUBMIT THE REQUIRED INITIAL OR DEPOSIT PREMIUM:						
1. Credit Card (for applications submitted ONLINE at ncci.com ONLY) 2. Electronic funds transfer (EFT) in the form of an Automated Clearing House (ACH) transaction Note: For 1 & 2 above, refer to instructions provided within NCCI's <i>RMAPS® Online Application Service</i> payment screens. All payments by credit card and electronic funds transfer must accompany completed and signed ACORD 130 and 133 forms. 3. Check or Money Order (for MAILED applications ONLY)						
1. ONLY the following types of payment, made payable to NCCI, Inc., are acceptable: <ul style="list-style-type: none"> a. Checks: Applicant's, Cashier's, Producer's, Finance Company(s) b. Money Order 						
2. All checks and money orders MUST be made payable to NCCI, Inc., and accompany completed and signed ACORD 130 and 133 forms.						
NO CREDIT CARD OR BANKING INFORMATION SHOULD BE ENTERED ON THE HARDCOPY ACORD 130 or 133 FORMS. A DELAY IN PROCESSING YOUR APPLICATION MAY OCCUR SHOULD THIS INFORMATION BE INCLUDED ON THE SUBMITTED FORMS.						
By submitting this assigned risk workers compensation insurance application, the Applicant authorizes NCCI to debit the account name/number that the undersigned Applicant, or the undersigned Producer on Applicant's behalf, has designated and provided to NCCI, for the amount of this transaction. The Applicant further understands and agrees that all premium transactions and/or premium-related transactions must be processed and accepted by NCCI and the account name/number that the undersigned Applicant, or the undersigned Producer on Applicant's behalf, has designated and provided to NCCI, to be considered received by the Plan Administrator.						

APPLICANT'S STATEMENT

The undersigned Applicant hereby certifies that he/she has read and understands the questions and statements in this application, which is comprised of both the ACORD 130 and ACORD 133 forms. In consideration of coverage being afforded under the applicable Workers Compensation Insurance Plan developed or administered by NCCI (WCIP or Plan), by signing below, the Applicant also certifies that any and/or all responses provided in or to this application, which is comprised of both the ACORD 130 and ACORD 133 forms, are true and accurate and Applicant further understands and agrees that:

- Since he/she has been unable to secure workers compensation coverage in a regular manner through any other insurance carrier or provider, this coverage is being afforded under the applicable WCIP, and that the applicable rates and rating programs charged may be higher than those in the voluntary market.
- Coverage is NOT bound until the completed and signed application is received with the required initial or estimated annual deposit premium and eligibility is determined by the Plan Administrator.
- Provided that Applicant is determined to be eligible and in good faith entitled to WCIP insurance, based upon the information provided herein or otherwise available to the Plan Administrator, coverage will be bound in accordance with WCIP rules. See the WCIP for applicable binding rules.
- In approved jurisdictions, NCCI's Voluntary Coverage Assistance Program (*VCAP® Service*) applies to all employers seeking coverage under the Workers Compensation Insurance Plan, and:
 - Is integrated with and operates as a supplemental program to NCCI's WCIP; and
 - Operates in conjunction with NCCI's Residual Market Application Processing System (*RMAPS® Online Application Service*); and
 - Is designed as a depopulation tool to provide an additional source for producers and employers to secure workers compensation coverage in the voluntary market; and
 - All applications (electronic, phone-in, or mail-in) submitted to the Plan Administrator are reviewed to determine if they meet any of the preselected criteria specified by a participating voluntary carrier; and
 - If the Applicant meets the criteria of an authorized voluntary carrier (*VCAP® User*) and an offer of voluntary coverage is provided, the Applicant, its representative, and/or the producer, must accept a reasonable offer of voluntary coverage in accordance with the WCIP and *VCAP® Service* provisions, and further Applicant will be deemed ineligible for coverage under the WCIP if Applicant does not accept such reasonable offer of voluntary coverage; and
 - If an application does not meet any *VCAP® User's* criteria, the application will continue through NCCI's *RMAPS® Online Application Service*.

If deemed eligible under the WCIP and as further consideration of policy issuance under the WCIP, by signing below, the undersigned Applicant also agrees:

- To maintain a complete record of all payroll transactions in such form as the insurance company may reasonably require and that such record will be available to the company at the designated address; and
- To comply substantially with all laws, orders, rules, and regulations in force and effect issued by the public authorities relating to the welfare, health, and safety of employees; and
- To comply with all reasonable recommendations made by the insurance company relating to the welfare, health, and safety of employees; and
- To take no action in any form to evade the application of an experience rating modification determined in accordance with the applicable experience rating rules, as determined by NCCI, Inc.; and
- To comply with all WCIP rules and procedures and policy terms and conditions, including without limitation, those relating to audits, inspections, loss prevention, and/or premium payments, to maintain WCIP eligibility and coverage.

AGENCY CUSTOMER ID: _____

PRODUCER COMMUNICATIONS


1. By selecting the "Yes" option adjacent to this #1 section, the undersigned Producer consents and agrees to receive electronically transmitted information and/or communications issued by NCCI by means of electronic mail (email) messages that may contain electronic documents, including without limitation, any binder/verification pages issued by NCCI, and any notifications or other communications as determined by NCCI, to the email address provided by the Producer to NCCI. ☐ Yes ☒ NO
2. If "Yes" to #1 above, provide the valid email address to which the information, notifications and/or communications issued by NCCI should be electronically sent:
3. By selecting the "Yes" option adjacent to this #3 section, the undersigned Producer consents and agrees to receive electronically transmitted policy notifications and/or communications issued by the assigned carrier by means of electronic mail (email) messages that may contain electronic documents, including without limitation, any policy documents, cancellations, endorsements, renewal and/or nonrenewal notices, and any other policy notifications and/or communications as determined by the assigned carrier, but only to the extent that the assigned carrier is able and chooses in its discretion to transmit such policy notifications and/or communications electronically. If the assigned carrier is unable or does not choose to transmit such policy notifications and/or communications electronically, then hard copy policy notifications and/or communications will be provided to the Producer by the assigned carrier as determined by the assigned carrier, subject to any requirements applicable to the assigned carrier under any applicable laws or regulations. Regardless of the undersigned Producer's selection under this #3 section to receive electronically transmitted policy notifications and/or communications from the assigned carrier, the assigned carrier must comply with any applicable laws or regulations that require a specific method of delivery for policy notifications, documents, or other information, including without limitation, mailing notices of cancellation and/or nonrenewal of policies by certified mail or certificate of mailing. ☐ Yes ☒ NO
4. If "Yes" to #3 above, provide the valid email address to which policy notifications and/or communications issued by the assigned carrier should be electronically sent:

The undersigned Producer understands and agrees that by selecting the "Yes" option for #1 and/or #3 above, NCCI and the assigned carrier are authorized, but neither NCCI nor the assigned carrier separately is required or obligated, to electronically transmit any notifications and/or communications referenced in #1 and/or #3 above to the designated email address provided by the Producer in #2 and/or #4 above, as applicable. By consenting and agreeing to receive such electronically transmitted notifications and/or communications from NCCI and/or the assigned carrier, the undersigned Producer releases, indemnifies, and holds harmless NCCI and the assigned carrier from any and all claims pertaining to electronically transmitted notifications and/or communications utilizing the Producer's designated email address as provided to NCCI and/or the assigned carrier by the Producer in #2 and/or #4 above, as applicable, and including, without limitation, any changes and/or updates to the undersigned Producer's email address.

The undersigned Producer further understands and agrees that he/she shall notify NCCI and the assigned carrier of any and all changes and/or updates to Producer's email, mailing, and/or physical addresses, immediately upon making, implementing, or having knowledge of any such changes and/or updates.

PRODUCER'S CERTIFICATION

THE PRODUCER ALSO CERTIFIES THAT HE/SHE HAS BEEN AUTHORIZED TO SUBMIT THE APPLICATION ON BEHALF OF THE APPLICANT AND THAT ALL INFORMATION PROVIDED ON THE ACORD 130 AND 133 IS TRUE AND ACCURATE TO THE BEST OF HIS/HER KNOWLEDGE AND BELIEF.

AGENCY FEIN 58-1294268	AGENCY LICENSE NUMBER 096142	AGENCY PHONE NUMBER (A/C, No, Ext) (770) 717-7380	AGENCY FAX NUMBER (A/C, No) (770) 717-7482
PRODUCER RESIDENT LICENSE NUMBER 497524	STATE GA	EXPIRATION DATE 07/30/2018	PRODUCER NON-RESIDENT LICENSE NUMBER STATE EXPIRATION DATE
PRODUCER NAME (PRINT OR TYPE) VICKI NEVILLE		PRODUCER SIGNATURE 	DATE (MM/DD/YYYY) 6-15-17
E-MAIL ADDRESS: VICKI@FOSTERWITMER.COM			

REMEMBER: BOTH THE ACORD 130 AND 133 APPLICATIONS MUST BE SIGNED BY THE APPLICANT AND DESIGNATED PRODUCER

REMARKS (Attach additional sheets if more space is required)

NCCI APP# 42231500

WC-10 NOTICE OF ELECTION OR REJECTION OF WORKERS' COMPENSATION COVERAGE
GEORGIA STATE BOARD OF WORKERS' COMPENSATION
NOTICE OF ELECTION OR REJECTION
OF WORKERS' COMPENSATION COVERAGE

The use of this form is required under the provisions of: (A) O.C.G.A. §34-9-2.1 of the Workers' Compensation Law if a corporate officer or limited liability company member elects to reject coverage; (B) O.C.G.A. §34-9-2.2 if a sole proprietor or partner elects to be included as an employee; or (C) O.C.G.A. §34-9-2.3 if a farm labor employer elects to provide coverage for farm laborers. The election of corporate officers or LLC members to reject coverage shall not affect a corporate officer or LLC member being included in the count of the requisite number of employees. Any employer subject to this chapter pursuant to code Section §34-9-2(a) before the filing of any exemptions shall remain subject to this chapter without regard to the number of exemptions. **THIS FORM IS NOT A WAIVER OF COVERAGE AND SHOULD NOT BE ACCEPTED AS A WAIVER OF COVERAGE.**

A. CORPORATION / LIMITED LIABILITY COMPANY

I, EMIL SUIUGAN, certify that I am a member of Prime Painters LLC
(Type or Print Name) (Employer)
member 1760 Shady Creek Ln
(Office Held) (Street Address)
Lawrenceville, GA 30043
(City / State / Zip Code)

☒ I elect to reject the provisions of the Georgia Workers' Compensation Law.
☐ I elect to revoke the previous rejection of _____
(Date)

(NOTE: A maximum of five (5) officers / members may be exempted.)

B. SOLE PROPRIETOR OR PARTNER

I, _____, certify that I am a ☐ Sole Proprietor of _____
(Business Name)
☐ Partner

☐ I elect to be covered under the provisions of the Georgia Workers' Compensation Law.
☐ I elect to revoke the previous election of _____
(Date)

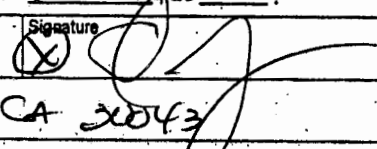
C. FARM LABOR

I, _____, certify that as the employer or representative of _____, that
(Business Name)

☐ I elect to provide Workers' Compensation coverage for farm laborers.
☐ I elect to revoke the previous election of _____
(Date)

D. CERTIFICATION

☒ I hereby certify that the information listed is true and correct, this the 15 day of June, 2017.

Print Name <u>Emil Suiugan</u>	Business Phone Number and Ext <u>770-827-1115</u>	Signature 
Business Address <u>1760 Shady Creek Ln Lawrenceville, GA 30043</u>		

A COPY OF THIS FORM MUST BE FILED WITH YOUR CURRENT WORKERS' COMPENSATION CARRIER. IF YOU DO NOT HAVE A CARRIER, AND THE BUSINESS HAS 3 TO 5 CORPORATE OFFICERS OR LIMITED LIABILITY MEMBERS AND NO EMPLOYEES, THIS FORM MUST BE FILED WITH THE STATE BOARD OF WORKERS' COMPENSATION AT 270 PEACHTREE STREET, N.W., ATLANTA, GEORGIA 30303-1299. NOTE: DO NOT SEND TO THE BOARD IF THERE IS INSURANCE COVERAGE.